CLAY COUNTY HOSPITAL

FLORA, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED FEBRUARY 29, 2016

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 07/21/2016 Time: 15:29 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLAY COUNTY HOSPITAL (14-1351) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 03/01/2015 and ending 02/29/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 07/21/2016 15:29
cU7zl33qVeNC5VSdVT0pvv4LAhVqy0
rcXT0U7ynGa3JeTubMhWnHnONeUAw
9IuH0rs9KN0ekHXy

PI Encryption: 07/21/2016 15:29
WDxGiLbLbBIlDubXJ6t1T3N0X773S0
vdX810NhHYTB.u5MEQu6BOLTixALVB
BGpQ0XolhN0sOxAg

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		467,832	-786,322	584,063	500,880	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		335,974				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			371,687			10
10.01	HEALTH CLINIC - RHC II						10.01
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		803,806	-414,635	584,063	500,880	200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 911 STACY BURK DRIVE	P.O. Box:			1
2	City: FLORA	State: IL	ZIP Code: 62839-0280	County: CLAY	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	CLAY COUNTY HOSPITAL	14-1351	99914	1	12 / 21 / 2005	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	CLAY COUNTY SWING BED	14-Z351	99914		12 / 21 / 2005	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	CLAY COUNTY MEDICAL CLINIC	14-3458	99914		11 / 29 / 2005	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	LOUISVILLE MEDICAL CLINIC	14-3487	99914		12 / 18 / 2006	N	O	N	15.01
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 03 / 01 / 2015	To: 02 / 29 / 2016	20
21	Type of control (see instructions)	9		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR§412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
	Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
	Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)						
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS				
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers				1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?			Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	118,000			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.		N	125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	Y		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	699,182			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2014	09 / 30 / 2014	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			Y	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	05/16/2016	Y	05/16/2016	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	Y		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	Y	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	Y	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render servcies to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information				
41	First name: MARK	Last name: W	Title: DALLAS	41
42	Employer: KERBER, ECK, & BRAECKEL			42
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM		43

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	22	8,030	192,720.00		2,015	581	3,262	1
2	HMO and other (see instructions)						88			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						1,233		1,233	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		22	8,030	192,720.00		3,248	581	4,495	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		22	8,030	192,720.00		3,248	581	4,495	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					7,580		25,971	26
26.01	RHC II	88.01								26.01
27	Total (sum of lines 14-26)		22							27
28	Observation Bed Days							34	148	28
29	Ambulance Trips						1,245			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					666	172	1,037	1
2	HMO and other (see instructions)								2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		177.30			666	172	1,037	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		32.20						26
26.01	RHC II								26.01
27	Total (sum of lines 14-26)		209.50						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	01/25/1985	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-3458** **WORKSHEET S-8**
STATISTICAL DATA

Check applicable box: **[XX] RHC** **[ ] FQHC**

Clinic Address and Identification:

1	Street: 929 STACY BURK DRIVE	1
2	City: FLORA State: IL ZIP Code: 62839 County: CLAY	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
10	Does this facility operate as other than an RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	Y	2	13
14	Provider name: CLAY COUNTY HOSPITAL CLIN CCN number: 14-3458			14
14.01	Provider name: LOUISVILLE MEDICAL CLINIC CCN number: 14-3487			14.01

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.395482	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	5,212,933	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	15,855,516	6
7	Medicaid cost (line 1 times line 6)	6,270,571	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	1,057,638	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care	138,046	17
18	Government grants, appropriations of transfers for support of hospital operations	287,220	18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,057,638	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	263,470	544,454	807,924	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	104,198	215,322	319,520	21
22	Partial payment by patients approved for charity care	40,403	451,265	491,668	22
23	Cost of charity care (line 21 minus line 22)	63,795	-235,943	-172,148	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,777,182	26
27	Medicare bad debts for the entire hospital complex (see instructions)	315,472	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,461,710	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	973,562	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	801,414	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,859,052	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,088,108	1,088,108	-151,154	936,954	-29,712	907,242	1
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT		11,652	11,652	145,932	157,584		157,584	1.01
2	00200	Cap Rel Costs-Mvble Equip		842,011	842,011	5,222	847,233		847,233	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	264,559	4,987,976	5,252,535		5,252,535	-863,026	4,389,509	4
5	00500	Administrative & General	1,392,595	2,833,408	4,226,003		4,226,003	-432,757	3,793,246	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	298,909	492,325	791,234		791,234		791,234	7
7.01	00701	RHC UTILITY EXPENSE		38,836	38,836		38,836		38,836	7.01
8	00800	Laundry & Linen Service		102,330	102,330		102,330		102,330	8
9	00900	Housekeeping	353,724	74,646	428,370		428,370		428,370	9
10	01000	Dietary	294,658	164,148	458,806	-330,792	128,014		128,014	10
11	01100	Cafeteria				330,792	330,792	-178,820	151,972	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	347,074	56,780	403,854		403,854		403,854	13
14	01400	Central Services & Supply	30,007	12,468	42,475		42,475		42,475	14
15	01500	Pharmacy	187,021	41,159	228,180		228,180		228,180	15
16	01600	Medical Records & Library	526,513	307,380	833,893		833,893	-3,270	830,623	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,179,374	128,610	2,307,984		2,307,984	-781,499	1,526,485	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	706,385	174,744	881,129	17,803	898,932		898,932	50
53	05300	Anesthesiology		352,351	352,351	-17,803	334,548	-334,548		53
54	05400	Radiology-Diagnostic	435,002	760,844	1,195,846		1,195,846		1,195,846	54
60	06000	Laboratory	489,676	1,107,753	1,597,429		1,597,429		1,597,429	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	374,924	58,165	433,089	-74,985	358,104		358,104	65
66	06600	Physical Therapy	514,034	55,310	569,344		569,344		569,344	66
69	06900	Electrocardiology		63,815	63,815	56,239	120,054		120,054	69
70	07000	Electroencephalography		62,784	62,784	18,746	81,530	-61,900	19,630	70
71	07100	Medical Supplies Charged to Patients		531,952	531,952	-21,232	510,720	-2,963	507,757	71
72	07200	Impl. Dev. Charged to Patients				21,232	21,232		21,232	72
73	07300	Drugs Charged to Patients		957,756	957,756		957,756		957,756	73
76	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		447,686	447,686		447,686		447,686	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	3,279,882	517,377	3,797,259	-56,657	3,740,602	-650,300	3,090,302	88
90	09000	Clinic	-109	72	-37	56,657	56,620		56,620	90
91	09100	Emergency	931,160	1,182,099	2,113,259		2,113,259	-542,974	1,570,285	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	862,108	129,651	991,759		991,759		991,759	95
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	13,467,496	17,584,196	31,051,692		31,051,692	-3,881,769	27,169,923	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	27,009	12,539	39,548		39,548		39,548	192
200		TOTAL (sum of lines 118-199)	13,494,505	17,596,735	31,091,240		31,091,240	-3,881,769	27,209,471	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRICIATION	A	NEW CAP RHC REL COSTS-BLDG &	1.01		140,561	1
500	Total reclassifications					140,561	500
	Code Letter - A						
1	RESPIRATORY THERAPY	B	Electrocardiology	69	56,239		1
2			Electroencephalography	70	18,746		2
500	Total reclassifications				74,985		500
	Code Letter - B						
1	INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	1.01		5,371	1
2			Cap Rel Costs-Mvble Equip	2		5,222	2
500	Total reclassifications					10,593	500
	Code Letter - C						
1	OPERATING ROOM	D	Operating Room	50		17,803	1
500	Total reclassifications					17,803	500
	Code Letter - D						
1	RECLASS PORTION OF DIETARY TO CAFE	E	Cafeteria	11	212,444	118,348	1
500	Total reclassifications				212,444	118,348	500
	Code Letter - E						
1	RECLASS IMPLANTABLE DEVICE COST	F	Impl. Dev. Charged to Patient	72		21,232	1
500	Total reclassifications					21,232	500
	Code Letter - F						
1	DIEBETIES EDUCATION	G	Clinic	90	56,657		1
500	Total reclassifications				56,657		500
	Code Letter - G						
	GRAND TOTAL (Increases)				344,086	308,537	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	DEPRICIATION	A	Cap Rel Costs-Bldg & Fixt	1		140,561	9	1
500	Total reclassifications					140,561		500
	Code letter - A							
1	RESPIRATORY THERAPY	B	Respiratory Therapy	65	74,985			1
2								2
500	Total reclassifications				74,985			500
	Code letter - B							
1	INSURANCE EXPENSE	C	Cap Rel Costs-Bldg & Fixt	1		10,593	12	1
2							12	2
500	Total reclassifications					10,593		500
	Code letter - C							
1	OPERATING ROOM	D	Anesthesiology	53		17,803		1
500	Total reclassifications					17,803		500
	Code letter - D							
1	RECLASS PORTION OF DIETARY TO CAFE	E	Dietary	10	212,444	118,348		1
500	Total reclassifications				212,444	118,348		500
	Code letter - E							
1	RECLASS IMPLANTABLE DEVICE COST	F	Medical Supplies Charged to P	71		21,232		1
500	Total reclassifications					21,232		500
	Code letter - F							
1	DIEBETIES EDUCATION	G	Rural Health Clinic	88	56,657			1
500	Total reclassifications				56,657			500
	Code letter - G							
	GRAND TOTAL (Decreases)				344,086	308,537		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	132,111	3,000		3,000		135,111		1
2	Land Improvements	345,852					345,852		2
3	Buildings and Fixtures	12,923,881	180,056		180,056		13,103,937		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	6,811,915	1,228,567		1,228,567	405,692	7,634,790		6
7	HIT-designated Assets	1,515,730	58,076		58,076		1,573,806		7
8	Subtotal (sum of lines 1-7)	21,729,489	1,469,699		1,469,699	405,692	22,793,496		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	21,729,489	1,469,699		1,469,699	405,692	22,793,496		10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	556,625		495,615	35,868			1,088,108	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT					11,652		11,652	1.01
2	Cap Rel Costs-Mvble Equip	726,221	115,790					842,011	2
3	Total (sum of lines 1-2)	1,282,846	115,790	495,615	35,868	11,652		1,941,771	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	13,584,900		13,584,900	0.595999					1
1.01	NEW CAP RHC REL COSTS-B				0.000000					1.01
2	Cap Rel Costs-Mvble Equ	9,208,596		9,208,596	0.404001					2
3	Total (sum of lines 1-2)	22,793,496		22,793,496	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	416,064		465,903	25,275			907,242	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	140,561			5,371	11,652		157,584	1.01
2	Cap Rel Costs-Mvble Equip	726,221	115,790		5,222			847,233	2
3	Total (sum of lines 1-2)	1,282,846	115,790	465,903	35,868	11,652		1,912,059	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-29,712	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-348	Administrative & General	5		4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-2,227	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,727,581				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-171	Administrative & General	5		11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-178,820	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-2,963	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-3,270	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines	B	-598	Administrative & General	5		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	PHYSICIAN EMPLOYEE BENEFITS	A	-254,178	Employee Benefits Department	4		33
34	MISCELLANEOUS REVENUE	B	-40,405	Administrative & General	5		34
35	PUBLIC RELATIONS	A	-383,097	Administrative & General	5		35
36	LOBBYING EXPENSE	A	-5,911	Administrative & General	5		36
37	CRNA EXPENSE	A	-334,548	Anesthesiology	53		37
38	EMPLOYEE BENEFITS LAB TESTS	A	-9,877	Employee Benefits Department	4		38
39	RHC PHYSICIAN HOSPITAL INCENTIVES	A	-266,349	Rural Health Clinic	88		39
40	PHYSICIAN RECRUITMENT	A	-42,743	Rural Health Clinic	88		40
41							41
42	PENSION DIFFERENTIAL	A	-598,971	Employee Benefits Department	4		42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,881,769				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	781,499	781,499						1
2	60	Laboratory AGGREGATE	16,000		16,000					2
3	65	Respiratory Therapy AGGREGATE								3
4	69	Electrocardiology AGGREGATE								4
5	70	Electroencephalograp AGGREGATE	61,900	61,900						5
6	88	Rural Health Clinic AGGREGATE	341,208	341,208						6
7	91	Emergency AGGREGATE	936,000	542,974	393,026					7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,136,607	1,727,581	409,026					200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE							781,499	1
2	60	Laboratory AGGREGATE								2
3	65	Respiratory Therapy AGGREGATE								3
4	69	Electrocardiology AGGREGATE								4
5	70	Electroencephalograp AGGREGATE							61,900	5
6	88	Rural Health Clinic AGGREGATE							341,208	6
7	91	Emergency AGGREGATE							542,974	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,727,581	200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	NEW RHC BUILDING FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	
		0	1	1.01	2	4	4A	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	907,242	907,242					1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	157,584		157,584				1.01
2	Cap Rel Costs-Mvble Equip	847,233			847,233			2
4	Employee Benefits Department	4,389,509				4,389,509		4
5	Administrative & General	3,793,246	395,917		284,577	462,044	4,935,784	5
6	Maintenance & Repairs							6
7	Operation of Plant	791,234	6,853		4,926	99,174	902,187	7
7.01	RHC UTILITY EXPENSE	38,836					38,836	7.01
8	Laundry & Linen Service	102,330					102,330	8
9	Housekeeping	428,370	4,990		3,587	117,361	554,308	9
10	Dietary	128,014	15,979		15,170	27,277	186,440	10
11	Cafeteria	151,972	5,127			70,486	227,585	11
12	Maintenance of Personnel							12
13	Nursing Administration	403,854	4,290		3,083	115,154	526,381	13
14	Central Services & Supply	42,475	7,451		5,356	9,956	65,238	14
15	Pharmacy	228,180	7,178		5,159	62,051	302,568	15
16	Medical Records & Library	830,623	56,242		40,426	174,690	1,101,981	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,526,485	104,384		75,029	723,086	2,428,984	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	898,932	69,504		49,958	234,369	1,252,763	50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,195,846	51,338		36,900	144,328	1,428,412	54
60	Laboratory	1,597,429	20,473		14,716	162,468	1,795,086	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	358,104	5,742		4,127	99,516	467,489	65
66	Physical Therapy	569,344		38,759	47,993	170,549	826,645	66
69	Electrocardiology	120,054	5,742		4,127	18,659	148,582	69
70	Electroencephalography	19,630	5,725		4,115	6,220	35,690	70
71	Medical Supplies Charged to Patients	507,757					507,757	71
72	Impl. Dev. Charged to Patients	21,232					21,232	72
73	Drugs Charged to Patients	957,756					957,756	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	447,686	44,126		31,717		523,529	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,090,302		107,813	133,500	1,069,417	4,401,032	88
90	Clinic	56,620				18,762	75,382	90
91	Emergency	1,570,285	47,766		34,333	308,946	1,961,330	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	991,759	21,260		15,281	286,035	1,314,335	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	27,169,923	880,087	146,572	814,080	4,380,548	27,089,642	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,597		3,304		7,901	190
192	Physicians' Private Offices	39,548	22,558	11,012	29,849	8,961	111,928	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	27,209,471	907,242	157,584	847,233	4,389,509	27,209,471	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5	7	7.01	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General	4,935,784						5
6	Maintenance & Repairs							6
7	Operation of Plant	199,922	1,102,109					7
7.01	RHC UTILITY EXPENSE	8,606		47,442				7.01
8	Laundry & Linen Service	22,676			125,006			8
9	Housekeeping	122,833	10,902			688,043		9
10	Dietary	41,315	34,909			14,261	276,925	10
11	Cafeteria	50,432	11,201			4,576		11
12	Maintenance of Personnel							12
13	Nursing Administration	116,644	9,371			3,828		13
14	Central Services & Supply	14,457	16,278			6,650		14
15	Pharmacy	67,048	15,681			6,406		15
16	Medical Records & Library	244,196	122,871			50,194		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	538,256	228,047		125,006	93,159	276,925	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	277,609	151,844			62,029		50
53	Anesthesiology							53
54	Radiology-Diagnostic	316,532	112,156			45,817		54
60	Laboratory	397,786	44,728			18,272		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	103,594	12,545			5,125		65
66	Physical Therapy	183,182		11,669		59,589		66
69	Electrocardiology	32,925	12,545			5,125		69
70	Electroencephalography	7,909	12,507			5,109		70
71	Medical Supplies Charged to Patients	112,517						71
72	Impl. Dev. Charged to Patients	4,705						72
73	Drugs Charged to Patients	212,236						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	116,012	96,400			39,380		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	975,256		32,458		165,756		88
90	Clinic	16,704						90
91	Emergency	434,625	104,353			42,629		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	291,253	46,445			18,973		95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,909,230	1,042,783	44,127	125,006	646,878	276,925	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,751	10,043			4,103		190
192	Physicians' Private Offices	24,803	49,283	3,315		37,062		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	4,935,784	1,102,109	47,442	125,006	688,043	276,925	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		11	13	14	15	16	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	RHC UTILITY EXPENSE							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	293,794						11
12	Maintenance of Personnel							12
13	Nursing Administration	9,363	665,587					13
14	Central Services & Supply	810	3,847	107,280				14
15	Pharmacy	5,045		806	397,554			15
16	Medical Records & Library	14,204				1,533,446		16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	58,795	174,637	2,788		76,153	4,002,750	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,057	90,566	30,306		75,647	1,959,821	50
53	Anesthesiology							53
54	Radiology-Diagnostic	11,735	55,772	6,621		346,044	2,323,089	54
60	Laboratory	13,210	62,781	45,696		278,188	2,655,747	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,092	48,069	1,790		46,114	692,818	65
66	Physical Therapy	13,868		761		75,347	1,171,061	66
69	Electrocardiology	1,517		4		22,184	222,882	69
70	Electroencephalography	506		7		11,899	73,627	70
71	Medical Supplies Charged to Patients			9,644		73,404	703,322	71
72	Impl. Dev. Charged to Patients			1,635		2,747	30,319	72
73	Drugs Charged to Patients				397,554	199,425	1,766,971	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					22,487	797,808	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	86,958		3,461		83,028	5,747,949	88
90	Clinic	1,526				7,242	100,854	90
91	Emergency	25,121	119,384	3,181		154,762	2,845,385	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	23,258	110,531	580		58,775	1,864,150	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	293,065	665,587	107,280	397,554	1,533,446	26,958,553	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						23,798	190
192	Physicians' Private Offices	729					227,120	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	293,794	665,587	107,280	397,554	1,533,446	27,209,471	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	RHC UTILITY EXPENSE							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		4,002,750					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,959,821					50
53	Anesthesiology							53
54	Radiology-Diagnostic		2,323,089					54
60	Laboratory		2,655,747					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		692,818					65
66	Physical Therapy		1,171,061					66
69	Electrocardiology		222,882					69
70	Electroencephalography		73,627					70
71	Medical Supplies Charged to Patients		703,322					71
72	Impl. Dev. Charged to Patients		30,319					72
73	Drugs Charged to Patients		1,766,971					73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		797,808					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		5,747,949					88
90	Clinic		100,854					90
91	Emergency		2,845,385					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		1,864,150					95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		26,958,553					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		23,798					190
192	Physicians' Private Offices		227,120					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		27,209,471					202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	NEW RHC BUILDING FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	
		0	1	1.01	2	2A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		395,917		284,577	680,494	680,494	5
6	Maintenance & Repairs							6
7	Operation of Plant		6,853		4,926	11,779	27,563	7
7.01	RHC UTILITY EXPENSE						1,186	7.01
8	Laundry & Linen Service						3,126	8
9	Housekeeping		4,990		3,587	8,577	16,935	9
10	Dietary		15,979		15,170	31,149	5,696	10
11	Cafeteria		5,127			5,127	6,953	11
12	Maintenance of Personnel							12
13	Nursing Administration		4,290		3,083	7,373	16,081	13
14	Central Services & Supply		7,451		5,356	12,807	1,993	14
15	Pharmacy		7,178		5,159	12,337	9,244	15
16	Medical Records & Library		56,242		40,426	96,668	33,667	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		104,384		75,029	179,413	74,208	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		69,504		49,958	119,462	38,273	50
53	Anesthesiology							53
54	Radiology-Diagnostic		51,338		36,900	88,238	43,639	54
60	Laboratory		20,473		14,716	35,189	54,842	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,742		4,127	9,869	14,282	65
66	Physical Therapy			38,759	47,993	86,752	25,255	66
69	Electrocardiology		5,742		4,127	9,869	4,539	69
70	Electroencephalography		5,725		4,115	9,840	1,090	70
71	Medical Supplies Charged to Patients						15,512	71
72	Impl. Dev. Charged to Patients						649	72
73	Drugs Charged to Patients						29,260	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		44,126		31,717	75,843	15,994	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			107,813	133,500	241,313	134,468	88
90	Clinic						2,303	90
91	Emergency		47,766		34,333	82,099	59,921	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		21,260		15,281	36,541	40,154	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		880,087	146,572	814,080	1,840,739	676,833	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,597		3,304	7,901	241	190
192	Physicians' Private Offices		22,558	11,012	29,849	63,419	3,420	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		907,242	157,584	847,233	1,912,059	680,494	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	7.01	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	39,342						7
7.01	RHC UTILITY EXPENSE		1,186					7.01
8	Laundry & Linen Service			3,126				8
9	Housekeeping	389			25,901			9
10	Dietary	1,246			537	38,628		10
11	Cafeteria	400			172		12,652	11
12	Maintenance of Personnel							12
13	Nursing Administration	335			144		403	13
14	Central Services & Supply	581			250		35	14
15	Pharmacy	560			241		217	15
16	Medical Records & Library	4,386			1,890		612	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,140		3,126	3,507	38,628	2,532	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,420			2,335		821	50
53	Anesthesiology							53
54	Radiology-Diagnostic	4,004			1,725		505	54
60	Laboratory	1,597			688		569	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	448			193		349	65
66	Physical Therapy		292		2,243		597	66
69	Electrocardiology	448			193		65	69
70	Electroencephalography	446			192		22	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,441			1,482			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		811		6,241		3,744	88
90	Clinic						66	90
91	Emergency	3,725			1,605		1,082	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,658			714		1,002	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	37,224	1,103	3,126	24,352	38,628	12,621	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	359			154			190
192	Physicians' Private Offices	1,759	83		1,395		31	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	39,342	1,186	3,126	25,901	38,628	12,652	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		13	14	15	16	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	RHC UTILITY EXPENSE							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	24,336						13
14	Central Services & Supply	141	15,807					14
15	Pharmacy		119	22,718				15
16	Medical Records & Library				137,223			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,383	411		6,814	323,162		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,312	4,465		6,769	180,857		50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,039	976		30,973	172,099		54
60	Laboratory	2,296	6,732		24,893	126,806		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,758	264		4,126	31,289		65
66	Physical Therapy		112		6,742	121,993		66
69	Electrocardiology		1		1,985	17,100		69
70	Electroencephalography		1		1,065	12,656		70
71	Medical Supplies Charged to Patients		1,421		6,568	23,501		71
72	Impl. Dev. Charged to Patients		241		246	1,136		72
73	Drugs Charged to Patients			22,718	17,845	69,823		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				2,012	98,772		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		510		7,430	394,517		88
90	Clinic				648	3,017		90
91	Emergency	4,365	469		13,848	167,114		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,042	85		5,259	89,455		95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,336	15,807	22,718	137,223	1,833,297		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					8,655		190
192	Physicians' Private Offices					70,107		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,336	15,807	22,718	137,223	1,912,059		202

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	RHC UTILITY EXPENSE							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	323,162						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	180,857						50
53	Anesthesiology							53
54	Radiology-Diagnostic	172,099						54
60	Laboratory	126,806						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	31,289						65
66	Physical Therapy	121,993						66
69	Electrocardiology	17,100						69
70	Electroencephalography	12,656						70
71	Medical Supplies Charged to Patients	23,501						71
72	Impl. Dev. Charged to Patients	1,136						72
73	Drugs Charged to Patients	69,823						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	98,772						76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	394,517						88
90	Clinic	3,017						90
91	Emergency	167,114						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	89,455						95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,833,297						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8,655						190
192	Physicians' Private Offices	70,107						192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,912,059						202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	NEW RHC BUILDING FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
		1	1.01	2	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	53,087						1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT		15,885					1.01
2	Cap Rel Costs-Mvble Equip			68,972				2
4	Employee Benefits Department				13,229,946			4
5	Administrative & General	23,167		23,167	1,392,595	-4,935,784	22,273,687	5
6	Maintenance & Repairs							6
7	Operation of Plant	401		401	298,909		902,187	7
7.01	RHC UTILITY EXPENSE						38,836	7.01
8	Laundry & Linen Service						102,330	8
9	Housekeeping	292		292	353,724		554,308	9
10	Dietary	935		1,235	82,214		186,440	10
11	Cafeteria	300			212,444		227,585	11
12	Maintenance of Personnel							12
13	Nursing Administration	251		251	347,074		526,381	13
14	Central Services & Supply	436		436	30,007		65,238	14
15	Pharmacy	420		420	187,021		302,568	15
16	Medical Records & Library	3,291		3,291	526,513		1,101,981	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,108		6,108	2,179,374		2,428,984	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067		4,067	706,385		1,252,763	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004		3,004	435,002		1,428,412	54
60	Laboratory	1,198		1,198	489,676		1,795,086	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336		336	299,939		467,489	65
66	Physical Therapy		3,907	3,907	514,034		826,645	66
69	Electrocardiology	336		336	56,239		148,582	69
70	Electroencephalography	335		335	18,746		35,690	70
71	Medical Supplies Charged to Patients						507,757	71
72	Impl. Dev. Charged to Patients						21,232	72
73	Drugs Charged to Patients						957,756	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582		2,582			523,529	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		10,868	10,868	3,223,225		4,401,032	88
90	Clinic				56,548		75,382	90
91	Emergency	2,795		2,795	931,160		1,961,330	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244		1,244	862,108		1,314,335	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	51,498	14,775	66,273	13,202,937	-4,935,784	22,153,858	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269		269			7,901	190
192	Physicians' Private Offices	1,320	1,110	2,430	27,009		111,928	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	907,242	157,584	847,233	4,389,509		4,935,784	202
203	Unit Cost Multiplier (Wkst. B, Part I)	17.089721	9.920302	12.283724	0.331786		0.221597	203
204	Cost to be allocated (Per Wkst. B, Part II)						680,494	204
205	Unit Cost Multiplier (Wkst. B, Part II)						0.030551	205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	RHC UTILITY EXPENSE SQUARE FEET	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	
		7	7.01	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	29,519						7
7.01	RHC UTILITY EXPENSE		15,885					7.01
8	Laundry & Linen Service			3,262				8
9	Housekeeping	292			45,112			9
10	Dietary	935			935	3,262		10
11	Cafeteria	300			300		10,890,060	11
12	Maintenance of Personnel							12
13	Nursing Administration	251			251		347,074	13
14	Central Services & Supply	436			436		30,007	14
15	Pharmacy	420			420		187,021	15
16	Medical Records & Library	3,291			3,291		526,513	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,108		3,262	6,108	3,262	2,179,374	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067			4,067		706,385	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004			3,004		435,002	54
60	Laboratory	1,198			1,198		489,676	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336			336		299,939	65
66	Physical Therapy		3,907		3,907		514,034	66
69	Electrocardiology	336			336		56,239	69
70	Electroencephalography	335			335		18,746	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582			2,582			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		10,868		10,868		3,223,225	88
90	Clinic						56,548	90
91	Emergency	2,795			2,795		931,160	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244			1,244		862,108	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	27,930	14,775	3,262	42,413	3,262	10,863,051	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269			269			190
192	Physicians' Private Offices	1,320	1,110		2,430		27,009	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,102,109	47,442	125,006	688,043	276,925	293,794	202
203	Unit Cost Multiplier (Wkst. B, Part I)	37.335580	2.986591	38.321888	15.251884	84.894237	0.026978	203
204	Cost to be allocated (Per Wkst. B, Part II)	39,342	1,186	3,126	25,901	38,628	12,652	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.332769	0.074662	0.958308	0.574149	11.841815	0.001162	205

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COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE			
		13	14	15	16			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	RHC UTILITY EXPENSE							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	5,191,394						13
14	Central Services & Supply	30,007	1,393,254					14
15	Pharmacy		10,464	548,455				15
16	Medical Records & Library				68,166,293			16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,362,132	36,206		3,385,186			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	706,385	393,590		3,362,685			50
53	Anesthesiology							53
54	Radiology-Diagnostic	435,002	85,989		15,383,532			54
60	Laboratory	489,676	593,466		12,366,110			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	374,924	23,243		2,049,857			65
66	Physical Therapy		9,878		3,349,345			66
69	Electrocardiology		46		986,115			69
70	Electroencephalography		95		528,940			70
71	Medical Supplies Charged to Patients		125,250		3,262,958			71
72	Impl. Dev. Charged to Patients		21,232		122,118			72
73	Drugs Charged to Patients			548,455	8,864,891			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				999,617			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		44,950		3,690,788			88
90	Clinic				321,929			90
91	Emergency	931,160	41,317		6,879,524			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	862,108	7,528		2,612,698			95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,191,394	1,393,254	548,455	68,166,293			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	665,587	107,280	397,554	1,533,446			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.128210	0.077000	0.724862	0.022496			203
204	Cost to be allocated (Per Wkst. B, Part II)	24,336	15,807	22,718	137,223			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.004688	0.011345	0.041422	0.002013			205

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POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,002,750		4,002,750			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,959,821		1,959,821			50
53	Anesthesiology						53
54	Radiology-Diagnostic	2,323,089		2,323,089			54
60	Laboratory	2,655,747		2,655,747			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	692,818		692,818			65
66	Physical Therapy	1,171,061		1,171,061			66
69	Electrocardiology	222,882		222,882			69
70	Electroencephalography	73,627		73,627			70
71	Medical Supplies Charged to Patients	703,322		703,322			71
72	Impl. Dev. Charged to Patients	30,319		30,319			72
73	Drugs Charged to Patients	1,766,971		1,766,971			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	797,808		797,808			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	5,747,949		5,747,949			88
90	Clinic	100,854		100,854			90
91	Emergency	2,845,385		2,845,385			91
92	Observation Beds (Non-Distinct Part)	127,592		127,592			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,864,150		1,864,150			95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	27,086,145		27,086,145			200
201	Less Observation Beds	127,592		127,592			201
202	Total (line 200 minus line 201)	26,958,553		26,958,553			202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	2,902,383		2,902,383				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	648,459	2,714,226	3,362,685	0.582814			50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,176,248	14,207,284	15,383,532	0.151011			54
60	Laboratory	2,155,402	10,210,708	12,366,110	0.214760			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,670,495	379,362	2,049,857	0.337984			65
66	Physical Therapy	744,496	2,604,849	3,349,345	0.349639			66
69	Electrocardiology	70,000	916,115	986,115	0.226020			69
70	Electroencephalography	3,838	525,102	528,940	0.139197			70
71	Medical Supplies Charged to Patients	1,696,708	1,566,250	3,262,958	0.215547			71
72	Impl. Dev. Charged to Patients	11,651	110,467	122,118	0.248276			72
73	Drugs Charged to Patients	3,849,067	5,015,824	8,864,891	0.199322			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		999,617	999,617	0.798114			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		3,690,788	3,690,788				88
90	Clinic		321,929	321,929	0.313280			90
91	Emergency	225,866	6,653,658	6,879,524	0.413602			91
92	Observation Beds (Non-Distinct Part)		482,803	482,803	0.264273			92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		2,612,698	2,612,698	0.713496			95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	15,154,613	53,011,680	68,166,293				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	15,154,613	53,011,680	68,166,293				202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1351** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.582814		1,108,188			645,867		50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.151011		5,357,969			809,112		54
60	Laboratory	0.214760		4,516,896			970,049		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.337984		166,412			56,245		65
66	Physical Therapy	0.349639		819,443			286,509		66
69	Electrocardiology	0.226020		444,955			100,569		69
70	Electroencephalography	0.139197		186,130			25,909		70
71	Medical Supplies Charged to Pat	0.215547		596,709			128,619		71
72	Impl. Dev. Charged to Patients	0.248276		78,268			19,432		72
73	Drugs Charged to Patients	0.199322		2,332,645			464,947		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.798114		967,690			772,327		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.313280		321,929			100,854		90
91	Emergency	0.413602		2,135,177			883,113		91
92	Observation Beds (Non-Distinct	0.264273		141,668			37,439		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.713496							95
200	Subtotal (see instructions)			19,174,079			5,300,991		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			19,174,079			5,300,991		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z351** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.582814							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.151011							54
60	Laboratory	0.214760							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.337984							65
66	Physical Therapy	0.349639							66
69	Electrocardiology	0.226020							69
70	Electroencephalography	0.139197							70
71	Medical Supplies Charged to Pat	0.215547							71
72	Impl. Dev. Charged to Patients	0.248276							72
73	Drugs Charged to Patients	0.199322							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.798114							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.313280							90
91	Emergency	0.413602							91
92	Observation Beds (Non-Distinct	0.264273							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.713496							95
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1351** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[ ] PPS	
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA	
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[XX] Other	

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,643	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,410	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,262	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,028	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	205	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,015	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	1,028	10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	205	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	135.00	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	139.00	20
21	Total general inpatient routine service cost (see instructions)	4,002,750	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	1,062,969	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,939,781	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,939,781	37

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1351** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	862.10	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,737,132	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	1,737,132	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,440,816	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,177,948	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)		52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	886,239	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	176,731	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	1,062,970	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1351** **WORKSHEET D-1**
PARTS III & IV

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] PPS**	
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**	
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**	

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					148	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					862.11	88
89	Observation bed cost (line 87 x line 88) (see instructions)					127,592	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	323,162	4,002,750	0.080735	127,592	10,301	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1351** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/IID**	**[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,794,389		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.582814	384,740	224,232	50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.151011	462,123	69,786	54
60	Laboratory	0.214760	1,032,896	221,825	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.337984	846,405	286,071	65
66	Physical Therapy	0.349639	253,227	88,538	66
69	Electrocardiology	0.226020	58,524	13,228	69
70	Electroencephalography	0.139197	3,838	534	70
71	Medical Supplies Charged to Patients	0.215547	864,749	186,394	71
72	Impl. Dev. Charged to Patients	0.248276	8,543	2,121	72
73	Drugs Charged to Patients	0.199322	1,709,917	340,824	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.798114			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.313280			90
91	Emergency	0.413602	17,561	7,263	91
92	Observation Beds (Non-Distinct Part)	0.264273			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		5,642,523	1,440,816	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,642,523		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z351** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other] [XX] Swing Bed SNF [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/IID [XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.582814			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.151011	37,335	5,638	54
60	Laboratory	0.214760	461,349	99,079	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.337984	542,397	183,322	65
66	Physical Therapy	0.349639	448,749	156,900	66
69	Electrocardiology	0.226020	8,219	1,858	69
70	Electroencephalography	0.139197			70
71	Medical Supplies Charged to Patients	0.215547	362,259	78,084	71
72	Impl. Dev. Charged to Patients	0.248276			72
73	Drugs Charged to Patients	0.199322	1,050,722	209,432	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.798114			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.313280			90
91	Emergency	0.413602	3,425	1,417	91
92	Observation Beds (Non-Distinct Part)	0.264273			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		2,914,455	735,730	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,914,455		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1351** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,300,991			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,300,991			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	5,354,001			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	52,258			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,944,842			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,356,901			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,356,901			30
31	Primary payer payments	300			31
32	Subtotal (line 30 minus line 31)	2,356,601			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	356,278			34
35	Adjusted reimbursable bad debts (see instructions)	231,581			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	356,278			36
37	Subtotal (see instructions)	2,588,182			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,588,182			40
40.01	Sequestration adjustment (see instructions)	51,764			40.01
41	Interim payments	3,322,740			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-786,322			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1351** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,140,471		3,488,115	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	06/15/2015	227,957	06/15/2015	67,853	3.01
	amount based on subsequent revision of the interim		.02	11/25/2015	105,394			3.02
	rate for the cost reporting period. Also show date of	Program	.03	02/25/2016	255,424			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	05/26/2015	399,669	05/26/2015	82,627	3.50
			.51			11/25/2015	150,601	3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		189,106		-165,375	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				2,329,577		3,322,740	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z351** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [XX] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,426,974			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	11/25/2015	16,552			3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		16,552			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,443,526			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	1,037	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,015	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	88	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	3,262	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	68,166,293	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	807,924	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	699,182	7
8	Calculation of the HIT incentive payment (see instructions)	595,983	8
9	Sequestration adjustment amount (see instructions)	11,920	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	584,063	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	584,063	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z351** **WORKSHEET E-2**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX** **[XX] Swing Bed - SNF** **[ ] Swing Bed - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	1,073,600		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	743,087		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,233		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,816,687		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,816,687		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,816,687		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	871		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,815,816		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	1,815,816		19
19.01	Sequestration adjustment (see instructions)	36,316		19.01
20	Interim payments	1,443,526		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	335,974		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART V

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT

1	Inpatient services	3,177,948	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	3,177,948	4
5	Primary payer payments		5
6	Total cost (see instructions)	3,209,727	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	3,209,727	19
20	Deductibles (exclude professional component)	407,253	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,802,474	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	2,802,474	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	80,038	25
26	Adjusted reimbursable bad debts (see instructions)	52,025	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	80,038	27
28	Subtotal (sum of lines 24 and 26)	2,854,499	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,854,499	30
30.01	Sequestration adjustment (see instructions)	57,090	30.01
31	Interim payments	2,329,577	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	467,832	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	1,829,875				1
2	Temporary investments	340,113				2
3	Notes receivable					3
4	Accounts receivable	6,510,258				4
5	Other receivables	299,380				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	272,460				7
8	Prepaid expenses	658,893				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	9,910,979				11
	FIXED ASSETS					
12	Land	135,111				12
13	Land improvements	345,852				13
14	Accumulated depreciation	-293,896				14
15	Buildings	13,103,938				15
16	Accumulated depreciation	-9,231,392				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	7,801,171				19
20	Accumulated depreciation	-5,691,646				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment					23
24	Accumulated depreciation					24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,573,806				27
28	Accumulated depreciation	-1,231,550				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	6,511,394				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	6,962,327				34
35	Total other assets (sum of lines 31-34)	6,962,327				35
36	Total assets (sum of lines 11, 30 and 35)	23,384,700				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,878,960				37
38	Salaries, wages and fees payable	829,849				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	481,703				44
45	Total current liabilities (sum of lines 37 thru 44)	3,190,512				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	2,138,300				47
48	Unsecured loans					48
49	Other long term liabilities	3,879,280				49
50	Total long term liabilities (sum of lines 46 thru 49)	6,017,580				50
51	Total liabilities (sum of lines 45 and 50)	9,208,092				51
	CAPITAL ACCOUNTS					
52	General fund balance	14,176,608				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	14,176,608				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	23,384,700				60

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		15,907,194			1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,862,659			2
3	Total (sum of line 1 and line 2)		14,044,535			3
4	Additions (credit adjustments) (specify)					4
5	PRIOR PERIOD ADJUSTMENT	132,073				5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		132,073			10
11	Subtotal (line 3 plus line 10)		14,176,608			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,176,608			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	PRIOR PERIOD ADJUSTMENT					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,290,314		3,290,314	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	3,290,314		3,290,314	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	3,290,314		3,290,314	17
18	Ancillary services	12,560,447		12,560,447	18
19	Outpatient services		47,899,350	47,899,350	19
20	Rural Health Clinic (RHC)		4,437,482	4,437,482	20
20.01	RHC II				20.01
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance		2,612,698	2,612,698	23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		59,721	59,721	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	15,850,761	55,009,251	70,860,012	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		31,091,240	29
30	Add (specify)	2		30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		2	36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		31,091,242	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	70,860,012	1
2	Less contractual allowances and discounts on patients' accounts	42,334,997	2
3	Net patient revenues (line 1 minus line 2)	28,525,015	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	31,091,242	4
5	Net income from service to patients (line 3 minus line 4)	-2,566,227	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	187,422	6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	178,820	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	3,270	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (TAX REVENUE)	203,735	24
24.01	Other (RENTAL INCOME)	63,251	24.01
24.02	Other (MISCELLANEOUS INCOME)	44,485	24.02
24.03	Other (GRANT INCOME)	81,071	24.03
24.04	Other (EHR INCENTIVE)		24.04
25	Total other income (sum of lines 6-24)	762,054	25
26	Total (line 5 plus line 25)	-1,804,173	26
27	Other expenses (GAIN/(LOSS) ON DISPOSAL)	5,792	27
27.01	Other expenses (LOSS ON INVESTMENTS)	52,694	27.01
28	Total other expenses (sum of line 27 and subscripts)	58,486	28
29	Net income (or loss) for the period (line 26 minus line 28)	-1,862,659	29

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	RHC UTILITY EXPENSE							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-3458** **WORKSHEET M-1**

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	665,777		665,777		665,777	-607,559	58,218	1
2	Physician Assistant								2
3	Nurse Practitioner	1,114,833		1,114,833		1,114,833		1,114,833	3
4	Visiting Nurse								4
5	Other Nurse	784,138		784,138		784,138		784,138	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	70,580		70,580		70,580		70,580	9
10	Subtotal (sum of lines 1 through 9)	2,635,328		2,635,328		2,635,328	-607,559	2,027,769	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		162,050	162,050		162,050		162,050	11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement		127,884	127,884		127,884		127,884	13
14	Subtotal (sum of lines 11 through 13)		289,934	289,934		289,934		289,934	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		60,265	60,265		60,265		60,265	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		20,384	20,384		20,384		20,384	18
19	Other Health Care Costs		146,797	146,797		146,797	-42,743	104,054	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		227,446	227,446		227,446	-42,743	184,703	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,635,328	517,380	3,152,708		3,152,708	-650,302	2,502,406	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs	644,553		644,553	-56,657	587,896		587,896	29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)	644,553		644,553	-56,657	587,896		587,896	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	3,279,881	517,380	3,797,261	-56,657	3,740,604	-650,302	3,090,302	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3458** **WORKSHEET M-2**

Check applicable box: **[XX] RHC I** **[ ] FQHC**

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	2.18	10,947	4,200	9,156		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	3.69	15,023	2,100	7,749		3
4	Subtotal (sum of lines 1 through 3)	5.87	25,970		16,905	25,970	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	5.87	25,970			25,970	8
9	Physician Services Under Agreements		1			1	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,502,406	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	2,502,406	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	587,896	14
15	Parent provider overhead allocated to facility (see instructions)	2,657,647	15
16	Total overhead (sum of lines 14 and 15)	3,245,543	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	3,245,543	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	3,245,543	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	5,747,949	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3458** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	5,747,949	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	15,573	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	5,732,376	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	25,970	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	1	5
6	Total adjusted visits (line 4 plus line 5)	25,971	6
7	Adjusted cost per visit (line 3 divided by line 6)	220.72	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	220.72	220.72	220.72	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		7,580		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,673,058		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,673,058		16
16.01	Total program charges (see instructions)(from contractor's records)				16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		1,277,778		16.04
16.05	Total program cost (see instructions)		1,277,778		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		75,836		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		191,325		19
20	Net Medicare cost excluding vaccines (see instructions)		1,277,778		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		15,573		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,293,351		22
23	Allowable bad debts (see instructions)		49,024		23
23.01	Adjusted reimbursable bad debts (see instructions)		31,866		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		49,024		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,325,217		26
26.01	Sequestration adjustment (see instructions)		26,504		26.01
27	Interim payments		927,026		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		371,687		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3458** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,027,769	2,027,769	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000109	0.000971	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	221	1,969	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	966	3,625	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,187	5,594	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,502,406	2,502,406	6
7	Total overhead (from Wkst. M-2, line 16)	3,245,543	3,245,543	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000474	0.002235	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,538	7,254	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,725	12,848	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	14	125	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	194.64	102.78	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	14	125	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,725	12,848	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		15,573	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		15,573	16

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2015 To: 02/29/2016	Run Date: 07/21/2016 Run Time: 15:29 Version: 2016.05 (06/20/2016)

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3458

WORKSHEET M-5

Check applicable box: [XX] RHC I [ ] FQHC

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				908,238	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02	11/25/2015	18,788	3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		18,788	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				927,026	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01			6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)					

8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.