CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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: 07/28/2017 Time: 08:27 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 03/01/2016 and ending 02/28/2017, 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.

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

C
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		294,978	-80,927	53,139	330,693	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		66,786				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			35,609			10
10.01	HEALTH CLINIC - RHC II						10.01
10.02	HEALTH CLINIC - RHC III						10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		361,764	-45,318	53,139	330,693	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
15.02	Hospital-Based Health Clinic - RHC III	CLAY COUNTY HOSPITAL CLAY CITY CLINI	14-8558	99914		09 / 02 / 2016	N	O	N	15.02
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 / 2016	To: 02 / 28 / 2017	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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:	119,967			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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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.	N		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)	58,600		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)	10 / 01 / 2015	09 / 30 / 2016	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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

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 Accountant? 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.	Y	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	04/28/2017	Y	04/28/2017	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.	N		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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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.	N	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 services 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: ANNA	Last name: C	Title: GUETERSLOH	41
42	Employer: KERBER, ECK, & BRAECKEL			42
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM		43

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	20	7,300	67,008.00		1,910	311	2,792	1
2	HMO and other (see instructions)						33			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						724		724	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		20	7,300	67,008.00		2,634	311	3,516	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)		20	7,300	67,008.00		2,634	311	3,516	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					7,756		32,332	26
26.01	RHC II	88.01								26.01
26.02	RHC III	88.02								26.02
27	Total (sum of lines 14-26)		20							27
28	Observation Bed Days							41	209	28
29	Ambulance Trips						1,290			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: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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)					608	103	869	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)		239.60			608	103	869	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		47.30						26
26.01	RHC II								26.01
26.02	RHC III								26.02
27	Total (sum of lines 14-26)		286.90						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71
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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3458** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 929 STACY BURK DRIVE	1
2	City: FLORA State: IL ZIP Code: 62839 County: CLAY	2
3	HOSPITAL-BASED 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 a hospital-based 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	RHC/FQHC 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

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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)	0.383981	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,352,525	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	15,237,811	6
7	Medicaid cost (line 1 times line 6)	5,851,030	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.	2,498,505	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	142,603	17
18	Government grants, appropriations of transfers for support of hospital operations	326,342	18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,498,505	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	438,425	2,360,331	2,798,756	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	168,347	906,322	1,074,669	21
22	Partial payment by patients approved for charity care	8,131	21,115	29,246	22
23	Cost of charity care (line 21 minus line 22)	160,216	885,207	1,045,423	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)	2,872,627	26
27	Medicare bad debts for the entire hospital complex (see instructions)	476,580	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,396,047	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	920,037	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,965,460	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,463,965	31

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		657,016	657,016	-153,679	503,337	-5,402	497,935	1
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT		11,449	11,449	148,229	159,678		159,678	1.01
2	00200	Cap Rel Costs-Mvble Equip		855,321	855,321	5,450	860,771	-126,866	733,905	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	188,657	5,739,742	5,928,399		5,928,399	-633,595	5,294,804	4
5	00500	Administrative & General	2,075,168	2,758,347	4,833,515		4,833,515	-532,525	4,300,990	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	287,886	567,472	855,358		855,358		855,358	7
7.01	00701	RHC UTILITY EXPENSE		40,089	40,089		40,089		40,089	7.01
8	00800	Laundry & Linen Service		117,565	117,565		117,565		117,565	8
9	00900	Housekeeping	338,530	55,340	393,870		393,870		393,870	9
10	01000	Dietary	317,916	162,176	480,092	-380,131	99,961		99,961	10
11	01100	Cafeteria				380,131	380,131	-156,469	223,662	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	201,845	38,560	240,405		240,405		240,405	13
14	01400	Central Services & Supply	30,172	35,884	66,056		66,056		66,056	14
15	01500	Pharmacy	196,568	242,427	438,995		438,995	-56,856	382,139	15
16	01600	Medical Records & Library	369,640	147,983	517,623		517,623	-13,740	503,883	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	1,901,317	247,106	2,148,423		2,148,423	-602,213	1,546,210	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	401,434	149,640	551,074	6,309	557,383		557,383	50
53	05300	Anesthesiology		285,886	285,886	-6,309	279,577	-279,577		53
54	05400	Radiology-Diagnostic	473,863	755,801	1,229,664		1,229,664		1,229,664	54
60	06000	Laboratory	531,852	1,028,275	1,560,127		1,560,127		1,560,127	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	400,641	52,256	452,897	-80,128	372,769		372,769	65
66	06600	Physical Therapy	510,357	89,715	600,072		600,072		600,072	66
69	06900	Electrocardiology		35,481	35,481	60,096	95,577		95,577	69
70	07000	Electroencephalography		15,624	15,624	20,032	35,656	-13,050	22,606	70
71	07100	Medical Supplies Charged to Patients		375,586	375,586	-39,999	335,587	-64,923	270,664	71
72	07200	Impl. Dev. Charged to Patients				39,999	39,999		39,999	72
73	07300	Drugs Charged to Patients		817,575	817,575		817,575	-452,555	365,020	73
76	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		486,786	486,786		486,786		486,786	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	3,848,440	544,236	4,392,676	-335,687	4,056,989	-537,399	3,519,590	88
90	09000	Clinic				54,705	54,705		54,705	90
91	09100	Emergency	1,005,758	1,124,283	2,130,041		2,130,041	-936,794	1,193,247	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	941,255	168,179	1,109,434		1,109,434		1,109,434	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)	14,021,299	17,605,800	31,627,099	-280,982	31,346,117	-4,411,964	26,934,153	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	38,381	11,082	49,463	280,982	330,445	-42,000	288,445	192
200		TOTAL (sum of lines 118-199)	14,059,680	17,616,882	31,676,562		31,676,562	-4,453,964	27,222,598	200

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		142,623	1
500	Total reclassifications					142,623	500
	Code Letter - A						
1	RESPIRATORY THERAPY	B	Electrocardiology	69	60,096		1
2			Electroencephalography	70	20,032		2
500	Total reclassifications				80,128		500
	Code Letter - B						
1	INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	1.01		5,606	1
2			Cap Rel Costs-Mvble Equip	2		5,450	2
500	Total reclassifications					11,056	500
	Code Letter - C						
1	OPERATING ROOM	D	Operating Room	50		6,309	1
500	Total reclassifications					6,309	500
	Code Letter - D						
1	RECLASS PORTION OF DIETARY TO CAFE	E	Cafeteria	11	251,722	128,409	1
500	Total reclassifications				251,722	128,409	500
	Code Letter - E						
1	RECLASS IMPLANTABLE DEVICE COST	F	Impl. Dev. Charged to Patient	72		39,999	1
500	Total reclassifications					39,999	500
	Code Letter - F						
1	DIEBETIES EDUCATION	G	Clinic	90	54,705		1
500	Total reclassifications				54,705		500
	Code Letter - G						
1	RECLASS CLINIC COSTS PRIOR RHC STAT	H	Physicians' Private Offices	192	238,074	42,908	1
500	Total reclassifications				238,074	42,908	500
	Code Letter - H						
	GRAND TOTAL (Increases)				624,629	371,304	

(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.

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		142,623	9	1
500	Total reclassifications					142,623		500
	Code letter - A							
1	RESPIRATORY THERAPY	B	Respiratory Therapy	65	80,128			1
2								2
500	Total reclassifications				80,128			500
	Code letter - B							
1	INSURANCE EXPENSE	C	Cap Rel Costs-Bldg & Fixt	1		11,056	12	1
2							12	2
500	Total reclassifications					11,056		500
	Code letter - C							
1	OPERATING ROOM	D	Anesthesiology	53		6,309		1
500	Total reclassifications					6,309		500
	Code letter - D							
1	RECLASS PORTION OF DIETARY TO CAFE	E	Dietary	10	251,722	128,409		1
500	Total reclassifications				251,722	128,409		500
	Code letter - E							
1	RECLASS IMPLANTABLE DEVICE COST	F	Medical Supplies Charged to P	71		39,999		1
500	Total reclassifications					39,999		500
	Code letter - F							
1	DIEBETIES EDUCATION	G	Rural Health Clinic	88	54,705			1
500	Total reclassifications				54,705			500
	Code letter - G							
1	RECLASS CLINIC COSTS PRIOR RHC STAT	H	Rural Health Clinic	88	238,074	42,908		1
500	Total reclassifications				238,074	42,908		500
	Code letter - H							
	GRAND TOTAL (Decreases)				624,629	371,304		

(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.

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	135,111					135,111		1
2	Land Improvements	345,852	5,816		5,816		351,668		2
3	Buildings and Fixtures	13,103,937	130,554		130,554	79,000	13,155,491		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	7,634,790	476,655		476,655	201,072	7,910,373		6
7	HIT-designated Assets	1,573,806					1,573,806		7
8	Subtotal (sum of lines 1-7)	22,793,496	613,025		613,025	280,072	23,126,449		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	22,793,496	613,025		613,025	280,072	23,126,449		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	564,724		54,857	37,435			657,016	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT					11,449		11,449	1.01
2	Cap Rel Costs-Mvble Equip	713,504	141,817					855,321	2
3	Total (sum of lines 1-2)	1,278,228	141,817	54,857	37,435	11,449		1,523,786	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	13,642,270		13,642,270	0.589899					1
1.01	NEW CAP RHC REL COSTS-B				0.000000					1.01
2	Cap Rel Costs-Mvble Equ	9,484,179		9,484,179	0.410101					2
3	Total (sum of lines 1-2)	23,126,449		23,126,449	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	422,101		49,455	26,379			497,935	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	142,623			5,606	11,449		159,678	1.01
2	Cap Rel Costs-Mvble Equip	586,638	141,817		5,450			733,905	2
3	Total (sum of lines 1-2)	1,151,362	141,817	49,455	37,435	11,449		1,391,518	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	-5,402	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)						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)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,727,172				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-217	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	-156,469	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-64,923	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-13,740	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						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	A	-126,866	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYSICIAN EMPLOYEE BENEFITS	A	-245,848	Employee Benefits Department	4		33
34	MISCELLANEOUS REVENUE	B	-164,956	Administrative & General	5		34
35	PUBLIC RELATIONS	A	-366,383	Administrative & General	5		35
36	LOBBYING EXPENSE	A	-969	Administrative & General	5		36
37	CRNA EXPENSE	A	-279,577	Anesthesiology	53		37
38	EMPLOYEE BENEFITS LAB TESTS	A	-30,985	Employee Benefits Department	4		38
39	RHC PHYSICIAN HOSPITAL INCENTIV	A	-355,500	Rural Health Clinic	88		39
40	PHYSICIAN RECRUITMENT	A	-6,784	Rural Health Clinic	88		40
41	CLINIC PHYSICIAN HOSPITAL INCENTIV	A	-42,000	Physicians' Private Offices	192		41
42	PENSION DIFFERENTIAL	A	-356,762	Employee Benefits Department	4		42
43	340B EXPENSES	A	-452,555	Drugs Charged to Patients	73		43
44	340B EXPENSES	A	-56,856	Pharmacy	15		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)		-4,453,964				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

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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	

(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	602,213	602,213						1
2	60	Laboratory AGGREGATE	1,500		1,500					2
3	65	Respiratory Therapy AGGREGATE								3
4	69	Electrocardiology AGGREGATE								4
5	70	Electroencephalograp AGGREGATE	13,050	13,050						5
6	88	Rural Health Clinic AGGREGATE	132,115	132,115						6
7	91	Emergency AGGREGATE	936,794	936,794						7
8	88	Rural Health Clinic AGGREGATE	43,000	43,000						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	1,728,672	1,727,172	1,500					200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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							602,213	1
2	60	Laboratory AGGREGATE								2
3	65	Respiratory Therapy AGGREGATE								3
4	69	Electrocardiology AGGREGATE								4
5	70	Electroencephalograp AGGREGATE							13,050	5
6	88	Rural Health Clinic AGGREGATE							132,115	6
7	91	Emergency AGGREGATE							936,794	7
8	88	Rural Health Clinic AGGREGATE							43,000	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							1,727,172	200

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	497,935	497,935					1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	159,678		159,678				1.01
2	Cap Rel Costs-Mvble Equip	733,905			733,905			2
4	Employee Benefits Department	5,294,804				5,294,804		4
5	Administrative & General	4,300,990	217,297		232,371	792,127	5,542,785	5
6	Maintenance & Repairs							6
7	Operation of Plant	855,358	3,761		4,022	109,891	973,032	7
7.01	RHC UTILITY EXPENSE	40,089					40,089	7.01
8	Laundry & Linen Service	117,565					117,565	8
9	Housekeeping	393,870	2,739		2,929	129,223	528,761	9
10	Dietary	99,961	8,770		12,387	25,267	146,385	10
11	Cafeteria	223,662	2,814			96,087	322,563	11
12	Maintenance of Personnel							12
13	Nursing Administration	240,405	2,354		2,518	77,048	322,325	13
14	Central Services & Supply	66,056	4,090		4,373	11,517	86,036	14
15	Pharmacy	382,139	3,939		4,213	75,033	465,324	15
16	Medical Records & Library	503,883	30,868		33,010	141,098	708,859	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	1,546,210	57,291		61,265	725,765	2,390,531	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	557,383	38,147		40,793	153,234	789,557	50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,229,664	28,176		30,131	180,882	1,468,853	54
60	Laboratory	1,560,127	11,237		12,016	203,017	1,786,397	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	372,769	3,152		3,370	122,345	501,636	65
66	Physical Therapy	600,072		31,066	39,188	194,812	865,138	66
69	Electrocardiology	95,577	3,152		3,370	22,940	125,039	69
70	Electroencephalography	22,606	3,142		3,360	7,647	36,755	70
71	Medical Supplies Charged to Patients	270,664					270,664	71
72	Impl. Dev. Charged to Patients	39,999					39,999	72
73	Drugs Charged to Patients	365,020					365,020	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	486,786	24,218		25,898		536,902	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	3,519,590		119,786	151,106	1,357,253	5,147,735	88
90	Clinic	54,705				20,882	75,587	90
91	Emergency	1,193,247	26,216		28,035	383,915	1,631,413	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,109,434	11,668		12,478	359,293	1,492,873	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)	26,934,153	483,031	150,852	706,833	5,189,276	26,777,823	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,523		2,698		5,221	190
192	Physicians' Private Offices	288,445	12,381	8,826	24,374	105,528	439,554	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	27,222,598	497,935	159,678	733,905	5,294,804	27,222,598	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	5,542,785						5
6	Maintenance & Repairs							6
7	Operation of Plant	248,771	1,221,803					7
7.01	RHC UTILITY EXPENSE	10,249		50,338				7.01
8	Laundry & Linen Service	30,057			147,622			8
9	Housekeeping	135,186	12,086			676,033		9
10	Dietary	37,426	38,700			12,819	235,330	10
11	Cafeteria	82,468	12,417			4,113		11
12	Maintenance of Personnel							12
13	Nursing Administration	82,408	10,389			3,441		13
14	Central Services & Supply	21,996	18,046			5,978		14
15	Pharmacy	118,968	17,384			5,758		15
16	Medical Records & Library	181,231	136,216			45,120		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	611,177	252,812		147,622	83,741	235,330	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	201,863	168,335			55,759		50
53	Anesthesiology							53
54	Radiology-Diagnostic	375,536	124,337			41,185		54
60	Laboratory	456,721	49,586			16,425		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	128,251	13,907			4,607		65
66	Physical Therapy	221,186		9,793		53,565		66
69	Electrocardiology	31,968	13,907			4,607		69
70	Electroencephalography	9,397	13,866			4,593		70
71	Medical Supplies Charged to Patients	69,200						71
72	Impl. Dev. Charged to Patients	10,226						72
73	Drugs Charged to Patients	93,323						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	137,268	106,870			35,400		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	1,316,096		37,763		206,543		88
90	Clinic	19,325						90
91	Emergency	417,097	115,686			38,320		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	381,677	51,490			17,055		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)	5,429,071	1,156,034	47,556	147,622	639,029	235,330	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,335	11,134			3,688		190
192	Physicians' Private Offices	112,379	54,635	2,782		33,316		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,542,785	1,221,803	50,338	147,622	676,033	235,330	202

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	421,561						11
12	Maintenance of Personnel							12
13	Nursing Administration	7,841	426,404					13
14	Central Services & Supply	1,172	2,545	135,773				14
15	Pharmacy	7,636		1,139	616,209			15
16	Medical Records & Library	14,360				1,085,786		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	73,862	107,224	3,451		55,112	3,960,862	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,595	33,867	29,652		49,251	1,343,879	50
53	Anesthesiology							53
54	Radiology-Diagnostic	18,409	39,977	7,975		251,925	2,328,197	54
60	Laboratory	20,661	44,870	63,384		192,417	2,630,461	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	12,451	33,800	1,627		23,723	720,002	65
66	Physical Therapy	19,826		648		47,715	1,217,871	66
69	Electrocardiology	2,335		12		18,944	196,812	69
70	Electroencephalography	778		81		1,935	67,405	70
71	Medical Supplies Charged to Patients			10,613		40,202	390,679	71
72	Impl. Dev. Charged to Patients			4,523		1,129	55,877	72
73	Drugs Charged to Patients				616,209	123,730	1,198,282	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					17,342	833,782	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	138,132		6,296		84,040	6,936,605	88
90	Clinic	2,125				2,431	99,468	90
91	Emergency	39,072	84,712	4,341		118,652	2,449,293	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	36,566	79,409	2,026		57,238	2,118,334	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)	410,821	426,404	135,768	616,209	1,085,786	26,547,809	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						21,378	190
192	Physicians' Private Offices	10,740		5			653,411	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	421,561	426,404	135,773	616,209	1,085,786	27,222,598	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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		3,960,862					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,343,879					50
53	Anesthesiology							53
54	Radiology-Diagnostic		2,328,197					54
60	Laboratory		2,630,461					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		720,002					65
66	Physical Therapy		1,217,871					66
69	Electrocardiology		196,812					69
70	Electroencephalography		67,405					70
71	Medical Supplies Charged to Patients		390,679					71
72	Impl. Dev. Charged to Patients		55,877					72
73	Drugs Charged to Patients		1,198,282					73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		833,782					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		6,936,605					88
90	Clinic		99,468					90
91	Emergency		2,449,293					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		2,118,334					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)		26,547,809					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		21,378					190
192	Physicians' Private Offices		653,411					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		27,222,598					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		217,297		232,371	449,668	449,668	5
6	Maintenance & Repairs							6
7	Operation of Plant		3,761		4,022	7,783	20,182	7
7.01	RHC UTILITY EXPENSE						831	7.01
8	Laundry & Linen Service						2,438	8
9	Housekeeping		2,739		2,929	5,668	10,967	9
10	Dietary		8,770		12,387	21,157	3,036	10
11	Cafeteria		2,814			2,814	6,690	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,354		2,518	4,872	6,685	13
14	Central Services & Supply		4,090		4,373	8,463	1,784	14
15	Pharmacy		3,939		4,213	8,152	9,651	15
16	Medical Records & Library		30,868		33,010	63,878	14,702	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		57,291		61,265	118,556	49,582	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		38,147		40,793	78,940	16,376	50
53	Anesthesiology							53
54	Radiology-Diagnostic		28,176		30,131	58,307	30,465	54
60	Laboratory		11,237		12,016	23,253	37,052	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,152		3,370	6,522	10,404	65
66	Physical Therapy			31,066	39,188	70,254	17,944	66
69	Electrocardiology		3,152		3,370	6,522	2,593	69
70	Electroencephalography		3,142		3,360	6,502	762	70
71	Medical Supplies Charged to Patients						5,614	71
72	Impl. Dev. Charged to Patients						830	72
73	Drugs Charged to Patients						7,571	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		24,218		25,898	50,116	11,136	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			119,786	151,106	270,892	106,779	88
90	Clinic						1,568	90
91	Emergency		26,216		28,035	54,251	33,837	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		11,668		12,478	24,146	30,964	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)		483,031	150,852	706,833	1,340,716	440,443	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,523		2,698	5,221	108	190
192	Physicians' Private Offices		12,381	8,826	24,374	45,581	9,117	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		497,935	159,678	733,905	1,391,518	449,668	202

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	27,965						7
7.01	RHC UTILITY EXPENSE		831					7.01
8	Laundry & Linen Service			2,438				8
9	Housekeeping	277			16,912			9
10	Dietary	886			321	25,400		10
11	Cafeteria	284			103		9,891	11
12	Maintenance of Personnel							12
13	Nursing Administration	238			86		184	13
14	Central Services & Supply	413			150		27	14
15	Pharmacy	398			144		179	15
16	Medical Records & Library	3,118			1,129		337	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	5,785		2,438	2,095	25,400	1,732	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,853			1,395		366	50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,846			1,030		432	54
60	Laboratory	1,135			411		485	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	318			115		292	65
66	Physical Therapy		162		1,340		465	66
69	Electrocardiology	318			115		55	69
70	Electroencephalography	317			115		18	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	2,446			886			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		623		5,166		3,244	88
90	Clinic						50	90
91	Emergency	2,648			959		916	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,179			427		857	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)	26,459	785	2,438	15,987	25,400	9,639	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	255			92			190
192	Physicians' Private Offices	1,251	46		833		252	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	27,965	831	2,438	16,912	25,400	9,891	202

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	12,065						13
14	Central Services & Supply	72	10,909					14
15	Pharmacy		92	18,616				15
16	Medical Records & Library				83,164			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	3,034	277		4,222	213,121		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	958	2,382		3,773	108,043		50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,131	641		19,291	114,143		54
60	Laboratory	1,270	5,092		14,739	83,437		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	956	131		1,817	20,555		65
66	Physical Therapy		52		3,655	93,872		66
69	Electrocardiology		1		1,451	11,055		69
70	Electroencephalography		7		148	7,869		70
71	Medical Supplies Charged to Patients		853		3,079	9,546		71
72	Impl. Dev. Charged to Patients		363		87	1,280		72
73	Drugs Charged to Patients			18,616	9,478	35,665		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				1,328	65,912		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		506		6,437	393,647		88
90	Clinic				186	1,804		90
91	Emergency	2,397	349		9,089	104,446		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	2,247	163		4,384	64,367		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)	12,065	10,909	18,616	83,164	1,328,762		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					5,676		190
192	Physicians' Private Offices					57,080		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	12,065	10,909	18,616	83,164	1,391,518		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	213,121						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	108,043						50
53	Anesthesiology							53
54	Radiology-Diagnostic	114,143						54
60	Laboratory	83,437						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	20,555						65
66	Physical Therapy	93,872						66
69	Electrocardiology	11,055						69
70	Electroencephalography	7,869						70
71	Medical Supplies Charged to Patients	9,546						71
72	Impl. Dev. Charged to Patients	1,280						72
73	Drugs Charged to Patients	35,665						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	65,912						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	393,647						88
90	Clinic	1,804						90
91	Emergency	104,446						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	64,367						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)	1,328,762						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,676						190
192	Physicians' Private Offices	57,080						192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,391,518						202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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		20,082					1.01
2	Cap Rel Costs-Mvble Equip			73,169				2
4	Employee Benefits Department				13,871,023			4
5	Administrative & General	23,167		23,167	2,075,168	-5,542,785	21,679,813	5
6	Maintenance & Repairs							6
7	Operation of Plant	401		401	287,886		973,032	7
7.01	RHC UTILITY EXPENSE						40,089	7.01
8	Laundry & Linen Service						117,565	8
9	Housekeeping	292		292	338,530		528,761	9
10	Dietary	935		1,235	66,194		146,385	10
11	Cafeteria	300			251,722		322,563	11
12	Maintenance of Personnel							12
13	Nursing Administration	251		251	201,845		322,325	13
14	Central Services & Supply	436		436	30,172		86,036	14
15	Pharmacy	420		420	196,568		465,324	15
16	Medical Records & Library	3,291		3,291	369,640		708,859	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	1,901,317		2,390,531	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067		4,067	401,434		789,557	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004		3,004	473,863		1,468,853	54
60	Laboratory	1,198		1,198	531,852		1,786,397	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336		336	320,513		501,636	65
66	Physical Therapy		3,907	3,907	510,357		865,138	66
69	Electrocardiology	336		336	60,096		125,039	69
70	Electroencephalography	335		335	20,032		36,755	70
71	Medical Supplies Charged to Patients						270,664	71
72	Impl. Dev. Charged to Patients						39,999	72
73	Drugs Charged to Patients						365,020	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582		2,582			536,902	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		15,065	15,065	3,555,661		5,147,735	88
90	Clinic				54,705		75,587	90
91	Emergency	2,795		2,795	1,005,758		1,631,413	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244		1,244	941,255		1,492,873	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	18,972	70,470	13,594,568	-5,542,785	21,235,038	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269		269			5,221	190
192	Physicians' Private Offices	1,320	1,110	2,430	276,455		439,554	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	497,935	159,678	733,905	5,294,804		5,542,785	202
203	Unit Cost Multiplier (Wkst. B, Part I)	9.379603	7.951300	10.030272	0.381717		0.255666	203
204	Cost to be allocated (Per Wkst. B, Part II)						449,668	204
205	Unit Cost Multiplier (Wkst. B, Part II)						0.020741	205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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		20,082					7.01
8	Laundry & Linen Service			2,792				8
9	Housekeeping	292			49,309			9
10	Dietary	935			935	2,792		10
11	Cafeteria	300			300		10,851,523	11
12	Maintenance of Personnel							12
13	Nursing Administration	251			251		201,845	13
14	Central Services & Supply	436			436		30,172	14
15	Pharmacy	420			420		196,568	15
16	Medical Records & Library	3,291			3,291		369,640	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		2,792	6,108	2,792	1,901,317	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067			4,067		401,434	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004			3,004		473,863	54
60	Laboratory	1,198			1,198		531,852	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336			336		320,513	65
66	Physical Therapy		3,907		3,907		510,357	66
69	Electrocardiology	336			336		60,096	69
70	Electroencephalography	335			335		20,032	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		15,065		15,065		3,555,661	88
90	Clinic						54,705	90
91	Emergency	2,795			2,795		1,005,758	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244			1,244		941,255	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	18,972	2,792	46,610	2,792	10,575,068	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269			269			190
192	Physicians' Private Offices	1,320	1,110		2,430		276,455	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,221,803	50,338	147,622	676,033	235,330	421,561	202
203	Unit Cost Multiplier (Wkst. B, Part I)	41.390393	2.506623	52.873209	13.710134	84.287249	0.038848	203
204	Cost to be allocated (Per Wkst. B, Part II)	27,965	831	2,438	16,912	25,400	9,891	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.947356	0.041380	0.873209	0.342980	9.097421	0.000911	205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	5,054,268						13
14	Central Services & Supply	30,171	1,200,730					14
15	Pharmacy		10,073	306,514				15
16	Medical Records & Library				69,138,298			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	1,270,935	30,519		3,509,188			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	401,434	262,231		3,136,028			50
53	Anesthesiology							53
54	Radiology-Diagnostic	473,863	70,530		16,042,911			54
60	Laboratory	531,852	560,558		12,251,950			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	400,641	14,387		1,510,531			65
66	Physical Therapy		5,728		3,038,209			66
69	Electrocardiology		106		1,206,267			69
70	Electroencephalography		719		123,200			70
71	Medical Supplies Charged to Patients		93,855		2,559,792			71
72	Impl. Dev. Charged to Patients		39,999		71,904			72
73	Drugs Charged to Patients			306,514	7,878,414			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				1,104,256			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		55,683		5,351,182			88
90	Clinic				154,816			90
91	Emergency	1,004,117	38,387		7,555,078			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	941,255	17,913		3,644,572			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)	5,054,268	1,200,688	306,514	69,138,298			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		42					192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	426,404	135,773	616,209	1,085,786			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.084365	0.113075	2.010378	0.015705			203
204	Cost to be allocated (Per Wkst. B, Part II)	12,065	10,909	18,616	83,164			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.002387	0.009085	0.060735	0.001203			205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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	3,960,862		3,960,862			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,343,879		1,343,879			50
53	Anesthesiology						53
54	Radiology-Diagnostic	2,328,197		2,328,197			54
60	Laboratory	2,630,461		2,630,461			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	720,002		720,002			65
66	Physical Therapy	1,217,871		1,217,871			66
69	Electrocardiology	196,812		196,812			69
70	Electroencephalography	67,405		67,405			70
71	Medical Supplies Charged to Patients	390,679		390,679			71
72	Impl. Dev. Charged to Patients	55,877		55,877			72
73	Drugs Charged to Patients	1,198,282		1,198,282			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	833,782		833,782			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	6,936,605		6,936,605			88
90	Clinic	99,468		99,468			90
91	Emergency	2,449,293		2,449,293			91
92	Observation Beds (Non-Distinct Part)	222,234		222,234			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	2,118,334		2,118,334			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)	26,770,043		26,770,043			200
201	Less Observation Beds	222,234		222,234			201
202	Total (line 200 minus line 201)	26,547,809		26,547,809			202

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	2,753,392		2,753,392				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	514,916	2,621,112	3,136,028	0.428529			50
53	Anesthesiology							53
54	Radiology-Diagnostic	920,038	15,122,873	16,042,911	0.145123			54
60	Laboratory	1,622,484	10,629,466	12,251,950	0.214697			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,083,173	427,358	1,510,531	0.476655			65
66	Physical Therapy	607,511	2,430,698	3,038,209	0.400852			66
69	Electrocardiology	67,067	1,139,200	1,206,267	0.163158			69
70	Electroencephalography		123,200	123,200	0.547119			70
71	Medical Supplies Charged to Patients	1,161,708	1,398,084	2,559,792	0.152621			71
72	Impl. Dev. Charged to Patients	16,203	55,701	71,904	0.777106			72
73	Drugs Charged to Patients	3,723,560	4,154,854	7,878,414	0.152097			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1,104,256	1,104,256	0.755062			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		5,351,182	5,351,182				88
90	Clinic		154,816	154,816	0.642492			90
91	Emergency	230,855	7,324,223	7,555,078	0.324192			91
92	Observation Beds (Non-Distinct Part)	20,792	735,004	755,796	0.294040			92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		3,644,572	3,644,572	0.581230			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)	12,721,699	56,416,599	69,138,298				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	12,721,699	56,416,599	69,138,298				202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	0.428529		1,065,090			456,422		50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.145123		5,777,860			838,500		54
60	Laboratory	0.214697		4,745,063			1,018,751		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.476655		187,416			89,333		65
66	Physical Therapy	0.400852		788,781			316,184		66
69	Electrocardiology	0.163158		562,828			91,830		69
70	Electroencephalography	0.547119		114,935			62,883		70
71	Medical Supplies Charged to Pat	0.152621		533,207			81,379		71
72	Impl. Dev. Charged to Patients	0.777106		55,701			43,286		72
73	Drugs Charged to Patients	0.152097		1,889,642			287,409		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.755062		1,093,501			825,661		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	0.642492		154,816			99,468		90
91	Emergency	0.324192		2,250,456			729,580		91
92	Observation Beds (Non-Distinct	0.294040		263,979			77,620		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.581230							95
200	Subtotal (see instructions)			19,483,275			5,018,306		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			19,483,275			5,018,306		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	0.428529							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.145123							54
60	Laboratory	0.214697							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.476655							65
66	Physical Therapy	0.400852							66
69	Electrocardiology	0.163158							69
70	Electroencephalography	0.547119							70
71	Medical Supplies Charged to Pat	0.152621							71
72	Impl. Dev. Charged to Patients	0.777106							72
73	Drugs Charged to Patients	0.152097							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.755062							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	0.642492							90
91	Emergency	0.324192							91
92	Observation Beds (Non-Distinct	0.294040							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.581230							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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	213,121	41,423	171,698	3,001	57.21	311	17,792	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	213,121		171,698	3,001		311	17,792	200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1351** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Hospital** **[ ] SUB (Other)** **[ ] Title XVIII, Part A** **[ ] IPF** **[XX] Title XIX** **[ ] IRF**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	108,043	3,136,028	0.034452			50
53	Anesthesiology						53
54	Radiology-Diagnostic	114,143	16,042,911	0.007115			54
60	Laboratory	83,437	12,251,950	0.006810			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	20,555	1,510,531	0.013608			65
66	Physical Therapy	93,872	3,038,209	0.030897			66
69	Electrocardiology	11,055	1,206,267	0.009165			69
70	Electroencephalography	7,869	123,200	0.063872			70
71	Medical Supplies Charged to Pat	9,546	2,559,792	0.003729			71
72	Impl. Dev. Charged to Patients	1,280	71,904	0.017802			72
73	Drugs Charged to Patients	35,665	7,878,414	0.004527			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	65,912	1,104,256	0.059689			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	393,647	5,351,182	0.073563			88
90	Clinic	1,804	154,816	0.011653			90
91	Emergency	104,446	7,555,078	0.013825			91
92	Observation Beds (Non-Distinct	11,958	755,796	0.015822			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,063,232	62,740,334				200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	3,001		311		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	3,001		311		200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1351** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XIX [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/IID [ ] PPS [ ] TEFRA [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	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 Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI							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							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services							95
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1351** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	3,136,028							50
53	Anesthesiology								53
54	Radiology-Diagnostic	16,042,911							54
60	Laboratory	12,251,950							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,510,531							65
66	Physical Therapy	3,038,209							66
69	Electrocardiology	1,206,267							69
70	Electroencephalography	123,200							70
71	Medical Supplies Charged to Pat	2,559,792							71
72	Impl. Dev. Charged to Patients	71,904							72
73	Drugs Charged to Patients	7,878,414							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1,104,256							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	5,351,182							88
90	Clinic	154,816							90
91	Emergency	7,555,078							91
92	Observation Beds (Non-Distinct	755,796							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	62,740,334							200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] 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	0.428529							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.145123							54
60	Laboratory	0.214697							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.476655							65
66	Physical Therapy	0.400852							66
69	Electrocardiology	0.163158							69
70	Electroencephalography	0.547119							70
71	Medical Supplies Charged to Pat	0.152621							71
72	Impl. Dev. Charged to Patients	0.777106							72
73	Drugs Charged to Patients	0.152097							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.755062							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	0.642492							90
91	Emergency	0.324192							91
92	Observation Beds (Non-Distinct	0.294040							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.581230							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: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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)	3,725	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,001	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)	2,792	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	603	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)	121	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)	1,910	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)	603	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)	121	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	139.98	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20
21	Total general inpatient routine service cost (see instructions)	3,960,862	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)	769,844	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,191,018	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)	3,191,018	37

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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

Check Applicable Boxes: **[ ] Title V - I/P** **[XX] Title XVIII, Part A** **[ ] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] PPS** **[ ] TEFRA** **[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)					1,063.32	38
39	Program general inpatient routine service cost (line 9 x line 38)					2,030,941	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)					2,030,941	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)					1,260,747	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					3,291,688	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)					641,182	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					128,662	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					769,844	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

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)					209	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,063.32	88
89	Observation bed cost (line 87 x line 88) (see instructions)					222,234	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	213,121	3,960,862	0.053807	222,234	11,958	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: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] 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)	3,725	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,001	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)	2,792	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	603	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)	121	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)	311	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)		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)		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	139.98	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20
21	Total general inpatient routine service cost (see instructions)	3,960,862	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)	769,844	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,191,018	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)	3,191,018	37

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)					1,063.32	38
39	Program general inpatient routine service cost (line 9 x line 38)					330,693	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)					330,693	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)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					330,693	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					17,792	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)					17,792	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)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						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

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
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					209	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						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						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: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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**

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,841,530		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.428529	343,285	147,108	50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.145123	340,813	49,460	54
60	Laboratory	0.214697	940,577	201,939	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.476655	696,093	331,796	65
66	Physical Therapy	0.400852	218,915	87,753	66
69	Electrocardiology	0.163158	54,026	8,815	69
70	Electroencephalography	0.547119			70
71	Medical Supplies Charged to Patients	0.152621	716,900	109,414	71
72	Impl. Dev. Charged to Patients	0.777106	13,990	10,872	72
73	Drugs Charged to Patients	0.152097	1,973,061	300,097	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.755062			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	0.642492			90
91	Emergency	0.324192	22,762	7,379	91
92	Observation Beds (Non-Distinct Part)	0.294040	20,792	6,114	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		5,341,214	1,260,747	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,341,214		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [ ] Title XIX | [ ] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [XX] Swing Bed SNF [ ] Swing Bed NF [ ] ICF/IID | [ ] PPS [ ] TEFRA [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	0.428529			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.145123	11,610	1,685	54
60	Laboratory	0.214697	153,831	33,027	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.476655	206,962	98,649	65
66	Physical Therapy	0.400852	367,603	147,354	66
69	Electrocardiology	0.163158	3,233	527	69
70	Electroencephalography	0.547119			70
71	Medical Supplies Charged to Patients	0.152621	117,055	17,865	71
72	Impl. Dev. Charged to Patients	0.777106			72
73	Drugs Charged to Patients	0.152097	452,561	68,833	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.755062			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	0.642492			90
91	Emergency	0.324192			91
92	Observation Beds (Non-Distinct Part)	0.294040			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		1,312,855	367,940	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,312,855		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[XX] 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	0.428529			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.145123			54
60	Laboratory	0.214697			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.476655			65
66	Physical Therapy	0.400852			66
69	Electrocardiology	0.163158			69
70	Electroencephalography	0.547119			70
71	Medical Supplies Charged to Patients	0.152621			71
72	Impl. Dev. Charged to Patients	0.777106			72
73	Drugs Charged to Patients	0.152097			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.755062			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	0.642492			90
91	Emergency	0.324192			91
92	Observation Beds (Non-Distinct Part)	0.294040			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

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)	5,018,306			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)	5,018,306			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)	5,068,489			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)	50,361			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,932,823			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)	2,085,305			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)	2,085,305			30
31	Primary payer payments	932			31
32	Subtotal (line 30 minus line 31)	2,084,373			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)	626,992			34
35	Adjusted reimbursable bad debts (see instructions)	407,545			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	544,706			36
37	Subtotal (see instructions)	2,491,918			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)	2,491,918			40
40.01	Sequestration adjustment (see instructions)	49,838			40.01
41	Interim payments	2,523,007			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-80,927			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

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

Check Applicable Boxes: **[XX] Hospital** **[ ] SUB (Other)** **[ ] IPF** **[ ] SNF** **[ ] IRF** **[ ] 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				2,593,703		3,150,888	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					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	02/23/2017	31,275	02/23/2017	627,881	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		-31,275		-627,881	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)				2,562,428		2,523,007	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		294,978			6.01
	based on the cost report (1)		.02				-80,927	6.02
7	Total Medicare program liability (see instructions)				2,857,406		2,442,080	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.

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

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [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				923,004			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	02/23/2017	135,739			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		135,739			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)				1,058,743			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		66,786			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,125,529			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: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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)	869	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,910	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	33	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	2,792	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	69,138,298	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,798,756	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	58,600	7
8	Calculation of the HIT incentive payment (see instructions)	54,223	8
9	Sequestration adjustment amount (see instructions)	1,084	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	53,139	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)	53,139	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: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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)	777,542		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)	371,619		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	724		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)	1,149,161		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,149,161		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,149,161		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	662		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)	1,148,499		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)	1,148,499		19
19.01	Sequestration adjustment (see instructions)	22,970		19.01
20	Interim payments	1,058,743		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	66,786		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	3,291,688	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	3,291,688	4
5	Primary payer payments		5
6	Total cost (see instructions)	3,324,605	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)	3,324,605	19
20	Deductibles (exclude professional component)	430,399	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,894,206	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	2,894,206	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33,099	25
26	Adjusted reimbursable bad debts (see instructions)	21,514	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,579	27
28	Subtotal (sum of lines 24 and 26)	2,915,720	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,915,720	30
30.01	Sequestration adjustment (see instructions)	58,314	30.01
31	Interim payments	2,562,428	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	294,978	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: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1351** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[ ] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[XX] Other**

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	330,693		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	330,693		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	330,693		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	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)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	330,693		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	330,693		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	330,693		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	330,693		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	330,693		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	330,693		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	330,693		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	3,337,265				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	6,038,680				4
5	Other receivables	475,128				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	224,442				7
8	Prepaid expenses	468,749				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,544,264				11
	FIXED ASSETS					
12	Land	135,111				12
13	Land improvements	351,668				13
14	Accumulated depreciation	-300,866				14
15	Buildings	13,155,491				15
16	Accumulated depreciation	-9,710,146				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	7,909,849				19
20	Accumulated depreciation	-6,020,059				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	1,574,330				27
28	Accumulated depreciation	-1,406,213				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	5,689,165				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,553,304				34
35	Total other assets (sum of lines 31-34)	4,553,304				35
36	Total assets (sum of lines 11, 30 and 35)	20,786,733				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	1,886,381				37
38	Salaries, wages and fees payable	1,057,354				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	801,068				44
45	Total current liabilities (sum of lines 37 thru 44)	3,744,803				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	2,138,300				47
48	Unsecured loans					48
49	Other long term liabilities	3,758,562				49
50	Total long term liabilities (sum of lines 46 thru 49)	5,896,862				50
51	Total liabilities (sum of lines 45 and 50)	9,641,665				51
	CAPITAL ACCOUNTS					
52	General fund balance	11,145,068				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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	
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)	11,145,068				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	20,786,733				60

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		13,438,629			1
2	Net income (loss) (from Worksheet G-3, line 29)		-2,293,561			2
3	Total (sum of line 1 and line 2)		11,145,068			3
4	Additions (credit adjustments) (specify)					4
5						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)		11,145,068			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)		11,145,068			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						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

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	2,753,391		2,753,391	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	270,773		270,773	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)	3,024,164		3,024,164	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)	3,024,164		3,024,164	17
18	Ancillary services	10,167,134		10,167,134	18
19	Outpatient services		48,344,361	48,344,361	19
20	Rural Health Clinic (RHC)		6,338,331	6,338,331	20
20.01	RHC II				20.01
20.02	RHC III				20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance		3,644,572	3,644,572	23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	13,191,298	58,327,264	71,518,562	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		31,676,562	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)	-1		37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-1	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		31,676,561	43

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	71,518,562	1
2	Less contractual allowances and discounts on patients' accounts	44,392,356	2
3	Net patient revenues (line 1 minus line 2)	27,126,206	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	31,676,561	4
5	Net income from service to patients (line 3 minus line 4)	-4,550,355	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	153,008	6
7	Income from investments	69,006	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	156,468	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	13,740	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)	206,542	24
24.01	Other (RENTAL INCOME)	82,935	24.01
24.02	Other (MISCELLANEOUS INCOME)	149,991	24.02
24.03	Other (GRANT INCOME)	120,875	24.03
24.04	Other (EHR INCENTIVE)	123,242	24.04
24.05	Other (340B PROGRAM REVENUE)	1,117,171	24.05
24.06	Other (SALE OF EQUIPMENT)	63,816	24.06
25	Total other income (sum of lines 6-24)	2,256,794	25
26	Total (line 5 plus line 25)	-2,293,561	26
27.01	Other expenses (LOSS ON INVESTMENTS)		27.01
29	Net income (or loss) for the period (line 26 minus line 28)	-2,293,561	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

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	810,859		810,859	-5,416	805,443	-132,115	673,328	1
2	Physician Assistant								2
3	Nurse Practitioner	957,082		957,082	-137,718	819,364	-355,500	463,864	3
4	Visiting Nurse								4
5	Other Nurse	842,543		842,543	-41,650	800,893		800,893	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	80,303		80,303	-2,385	77,918		77,918	9
10	Subtotal (sum of lines 1 through 9)	2,690,787		2,690,787	-187,169	2,503,618	-487,615	2,016,003	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		138,115	138,115		138,115	-38,500	99,615	11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement		162,194	162,194	-14,112	148,082	-4,500	143,582	13
14	Subtotal (sum of lines 11 through 13)		300,309	300,309	-14,112	286,197	-43,000	243,197	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		70,789	70,789	-4,941	65,848		65,848	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		-282	-282		-282		-282	18
19	Other Health Care Costs		173,420	173,420	-23,855	149,565	-6,784	142,781	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		243,927	243,927	-28,796	215,131	-6,784	208,347	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,690,787	544,236	3,235,023	-230,077	3,004,946	-537,399	2,467,547	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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	1,157,653		1,157,653	-105,610	1,052,043		1,052,043	29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)	1,157,653		1,157,653	-105,610	1,052,043		1,052,043	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	3,848,440	544,236	4,392,676	-335,687	4,056,989	-537,399	3,519,590	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	2.13	8,706	4,200	8,946		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	6.61	23,626	2,100	13,881		3
4	Subtotal (sum of lines 1 through 3)	8.74	32,332		22,827	32,332	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)	8.74	32,332			32,332	8
9	Physician Services Under Agreements						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)	2,467,547	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)	2,467,547	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)	1,052,043	14
15	Parent provider overhead allocated to facility (see instructions)	3,417,015	15
16	Total overhead (sum of lines 14 and 15)	4,469,058	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	4,469,058	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	4,469,058	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	6,936,605	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)	6,936,605	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	65,182	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	6,871,423	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	32,332	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	32,332	6
7	Adjusted cost per visit (line 3 divided by line 6)	212.53	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)	212.53	212.53	212.53	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		7,063		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,501,099		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)		1,501,099		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)		1,128,163		16.04
16.05	Total program cost (see instructions)		1,128,163		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		90,895		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		218,524		19
20	Net Medicare cost excluding vaccines (see instructions)		1,128,163		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		65,183		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,193,346		22
23	Allowable bad debts (see instructions)		73,109		23
23.01	Adjusted reimbursable bad debts (see instructions)		47,521		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		34,756		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,240,867		26
26.01	Sequestration adjustment (see instructions)		24,817		26.01
27	Interim payments		1,180,441		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		35,609		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: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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)	2,016,003	2,016,003	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000555	0.000816	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,119	1,645	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	17,574	2,848	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	18,693	4,493	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,467,547	2,467,547	6
7	Total overhead (from Wkst. M-2, line 16)	4,469,058	4,469,058	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.007576	0.001821	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	33,858	8,138	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	52,551	12,631	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	121	178	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	434.31	70.96	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	121	178	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	52,552	12,631	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)		65,182	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)		65,183	16

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2016 To: 02/28/2017	Run Date: 07/28/2017 Run Time: 08:27 Version: 2017.01 (07/04/2017)

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	
1	Total interim payments paid to provider				923,004	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	02/23/2017	257,437	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 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		257,437	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				1,180,441	
	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		35,609	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				1,216,050	

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.