CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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: 07/27/2018 Time: 15:01 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 CHIEF FINANCIAL 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 03/01/2017 and ending 02/28/2018, 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.

[X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

(Signed) JENNIFER VENABLE
Chief Financial Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER
Title

07/27/2018 15:01
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		359,748	-27,430		205,537	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		124,775				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			343,761			10
10.01	HEALTH CLINIC - RHC II						10.01
10.02	HEALTH CLINIC - RHC III						10.02
10.03	HEALTH CLINIC - RHC IV						10.03
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		484,523	316,331		205,537	200

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

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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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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:

							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	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
15.03	Hospital-Based Health Clinic - RHC IV	CISNE MEDICAL CLINIC	14-8569	99914		09 / 02 / 2016	N	O	N	15.03
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 / 2017	To: 02 / 28 / 2018	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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)(i) or (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)(i) or (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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 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 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers		1	2	
105	Does this hospital qualify as a 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

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.	N		111

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:	131,744			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 care related taxes as defined in §1983(w)(3) of the Act? 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 in column 2.			126

127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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

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 the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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)	1			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 / 2016	09 / 30 / 2017	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.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/21/2018	Y	06/21/2018	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: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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: ANNAG@KEBCPA.COM		43

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	175,200.00		1,476	187	2,153	1
2	HMO and other (see instructions)						95			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						752		752	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		20	7,300	175,200.00		2,228	187	2,905	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	175,200.00		2,228	187	2,905	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					6,044		27,729	26
26.01	RHC II	88.01								26.01
26.02	RHC III	88.02								26.02
26.03	RHC IV	88.03								26.03
27	Total (sum of lines 14-26)		20							27
28	Observation Bed Days							31	223	28
29	Ambulance Trips						1,268			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
33.01	LTCH site neutral days and discharges									33.01

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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)					447	61	637	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)		229.00			447	61	637	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		46.40						26
26.01	RHC II								26.01
26.02	RHC III								26.02
26.03	RHC IV								26.03
27	Total (sum of lines 14-26)		275.40						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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

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)	0.388654	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	4,527,298	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 and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	14,945,580	6
7	Medicaid cost (line 1 times line 6)	5,808,659	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	1,281,361	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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care	126,572	17
18	Government grants, appropriations of transfers for support of hospital operations	438,812	18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,281,361	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	378,579	2,236,017	2,614,596	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	147,136	2,236,017	2,383,153	21
22	Payments received from patients for amounts previously written off as charity care	15,974	22,943	38,917	22
23	Cost of charity care (line 21 minus line 22)	131,162	2,213,074	2,344,236	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	3,091,308	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	347,740	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	534,984	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,556,324	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,180,770	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,525,006	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,806,367	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		628,007	628,007	-166,590	461,417	-4,027	457,390	1
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT		8,129	8,129	165,248	173,377		173,377	1.01
2	00200	Cap Rel Costs-Mvble Equip		782,640	782,640	1,342	783,982	-108,997	674,985	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	183,325	5,849,886	6,033,211		6,033,211	-1,166,676	4,866,535	4
5	00500	Administrative & General	2,101,580	3,248,040	5,349,620		5,349,620	-449,005	4,900,615	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	306,547	516,338	822,885		822,885		822,885	7
7.01	00701	RHC UTILITY EXPENSE		47,804	47,804		47,804		47,804	7.01
8	00800	Laundry & Linen Service		105,274	105,274		105,274		105,274	8
9	00900	Housekeeping	297,383	49,841	347,224		347,224		347,224	9
10	01000	Dietary	324,368	156,883	481,251	-380,373	100,878		100,878	10
11	01100	Cafeteria				380,373	380,373	-147,789	232,584	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	254,239	32,780	287,019		287,019		287,019	13
14	01400	Central Services & Supply	30,576	17,999	48,575		48,575		48,575	14
15	01500	Pharmacy	192,742	357,554	550,296		550,296	-148,851	401,445	15
16	01600	Medical Records & Library	405,825	144,179	550,004		550,004	-7,771	542,233	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	1,702,738	218,343	1,921,081		1,921,081	-724,515	1,196,566	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	362,070	149,751	511,821	4,520	516,341		516,341	50
53	05300	Anesthesiology		302,181	302,181	-4,520	297,661	-297,661		53
54	05400	Radiology-Diagnostic	454,110	815,087	1,269,197		1,269,197		1,269,197	54
60	06000	Laboratory	567,973	980,713	1,548,686		1,548,686		1,548,686	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	393,956	56,280	450,236	-78,791	371,445		371,445	65
66	06600	Physical Therapy	529,323	71,027	600,350		600,350		600,350	66
69	06900	Electrocardiology		40,304	40,304	59,093	99,397		99,397	69
70	07000	Electroencephalography				19,698	19,698		19,698	70
71	07100	Medical Supplies Charged to Patients		457,489	457,489	-48,794	408,695	-2,540	406,155	71
72	07200	Impl. Dev. Charged to Patients				48,794	48,794		48,794	72
73	07300	Drugs Charged to Patients		739,148	739,148		739,148	-242,612	496,536	73
76	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		494,003	494,003		494,003		494,003	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	3,705,773	476,894	4,182,667	-53,074	4,129,593	-345,179	3,784,414	88
90	09000	Clinic				53,074	53,074		53,074	90
91	09100	Emergency	875,517	1,120,759	1,996,276		1,996,276		1,996,276	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	915,226	174,473	1,089,699		1,089,699		1,089,699	95
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	13,603,271	18,041,806	31,645,077		31,645,077	-3,645,623	27,999,454	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	26,455	8,464	34,919		34,919		34,919	192
200		TOTAL (sum of lines 118-199)	13,629,726	18,050,270	31,679,996		31,679,996	-3,645,623	28,034,373	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		163,868	1
500	Total reclassifications					163,868	500
	Code Letter - A						
1	RESPIRATORY THERAPY	B	Electrocardiology	69	59,093		1
2			Electroencephalography	70	19,698		2
500	Total reclassifications				78,791		500
	Code Letter - B						
1	INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	1.01		1,380	1
2			Cap Rel Costs-Mvble Equip	2		1,342	2
500	Total reclassifications					2,722	500
	Code Letter - C						
1	OPERATING ROOM	D	Operating Room	50		4,520	1
500	Total reclassifications					4,520	500
	Code Letter - D						
1	RECLASS PORTION OF DIETARY TO CAFE	E	Cafeteria	11	256,375	123,998	1
500	Total reclassifications				256,375	123,998	500
	Code Letter - E						
1	RECLASS IMPLANTABLE DEVICE COST	F	Impl. Dev. Charged to Patient	72		48,794	1
500	Total reclassifications					48,794	500
	Code Letter - F						
1	DIEBETIES EDUCATION	G	Clinic	90	53,074		1
500	Total reclassifications				53,074		500
	Code Letter - G						
	GRAND TOTAL (Increases)				388,240	343,902	

(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		163,868	9	1
500	Total reclassifications					163,868		500
	Code letter - A							
1	RESPIRATORY THERAPY	B	Respiratory Therapy	65	78,791			1
2								2
500	Total reclassifications				78,791			500
	Code letter - B							
1	INSURANCE EXPENSE	C	Cap Rel Costs-Bldg & Fixt	1		2,722	12	1
2							12	2
500	Total reclassifications					2,722		500
	Code letter - C							
1	OPERATING ROOM	D	Anesthesiology	53		4,520		1
500	Total reclassifications					4,520		500
	Code letter - D							
1	RECLASS PORTION OF DIETARY TO CAFE	E	Dietary	10	256,375	123,998		1
500	Total reclassifications				256,375	123,998		500
	Code letter - E							
1	RECLASS IMPLANTABLE DEVICE COST	F	Medical Supplies Charged to P	71		48,794		1
500	Total reclassifications					48,794		500
	Code letter - F							
1	DIEBETIES EDUCATION	G	Rural Health Clinic	88	53,074			1
500	Total reclassifications				53,074			500
	Code letter - G							
	GRAND TOTAL (Decreases)				388,240	343,902		

(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	351,668					351,668		2
3	Buildings and Fixtures	13,155,491	113,528		113,528		13,269,019		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	7,910,373	468,460		468,460	22,141	8,356,692		6
7	HIT-designated Assets	1,573,806					1,573,806		7
8	Subtotal (sum of lines 1-7)	23,126,449	581,988		581,988	22,141	23,686,296		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	23,126,449	581,988		581,988	22,141	23,686,296		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	579,952		38,841	9,214			628,007	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT					8,129		8,129	1.01
2	Cap Rel Costs-Mvble Equip	652,291	130,349					782,640	2
3	Total (sum of lines 1-2)	1,232,243	130,349	38,841	9,214	8,129		1,418,776	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	13,755,798		13,755,798	0.580749					1
1.01	NEW CAP RHC REL COSTS-B				0.000000					1.01
2	Cap Rel Costs-Mvble Equ	9,930,498		9,930,498	0.419251					2
3	Total (sum of lines 1-2)	23,686,296		23,686,296	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	416,084		34,814	6,492			457,390	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	163,868			1,380	8,129		173,377	1.01
2	Cap Rel Costs-Mvble Equip	543,294	130,349		1,342			674,985	2
3	Total (sum of lines 1-2)	1,123,246	130,349	34,814	9,214	8,129		1,305,752	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.)

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	-4,027	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)	B	-6,131	Administrative & General	5		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	-820,765				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-56	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	-147,789	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-2,540	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-7,771	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-34	Administrative & General	5		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-108,997	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYSICIAN EMPLOYEE BENEFITS	A	-265,733	Employee Benefits Department	4		33
34	MISCELLANEOUS REVENUE	B	-99,785	Administrative & General	5		34
35	PUBLIC RELATIONS	A	-336,108	Administrative & General	5		35
36	LOBBYING EXPENSE	A	-6,891	Administrative & General	5		36
37	CRNA EXPENSE	A	-297,661	Anesthesiology	53		37
38	EMPLOYEE BENEFITS LAB TESTS	A	-50,087	Employee Benefits Department	4		38
39	RHC PHYSICIAN HOSPITAL INCENTIV	A	-239,000	Rural Health Clinic	88		39
40	PHYSICIAN RECRUITMENT	A	-9,929	Rural Health Clinic	88		40
41	CLINIC PHYSICIAN HOSPITAL INCENTIV						41
42	PENSION DIFFERENTIAL	A	-850,856	Employee Benefits Department	4		42
43	340B EXPENSES	A	-242,612	Drugs Charged to Patients	73		43
44	340B EXPENSES	A	-148,851	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)		-3,645,623				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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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.

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:

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	724,515	724,515						1
2	60	Laboratory AGGREGATE	23,500		23,500					2
3	65	Respiratory Therapy AGGREGATE								3
4	69	Electrocardiology AGGREGATE								4
5	70	Electroencephalograp AGGREGATE								5
6	88	Rural Health Clinic AGGREGATE	70,650	70,650						6
7	91	Emergency AGGREGATE	936,000		936,000					7
8	88	Rural Health Clinic AGGREGATE	25,600	25,600						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	1,780,265	820,765	959,500					200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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							724,515	1
2	60	Laboratory AGGREGATE								2
3	65	Respiratory Therapy AGGREGATE								3
4	69	Electrocardiology AGGREGATE								4
5	70	Electroencephalograp AGGREGATE								5
6	88	Rural Health Clinic AGGREGATE							70,650	6
7	91	Emergency AGGREGATE								7
8	88	Rural Health Clinic AGGREGATE							25,600	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							820,765	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	457,390	457,390					1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	173,377		173,377				1.01
2	Cap Rel Costs-Mvble Equip	674,985			674,985			2
4	Employee Benefits Department	4,866,535				4,866,535		4
5	Administrative & General	4,900,615	199,601		213,714	760,606	6,074,536	5
6	Maintenance & Repairs							6
7	Operation of Plant	822,885	3,455		3,699	110,946	940,985	7
7.01	RHC UTILITY EXPENSE	47,804					47,804	7.01
8	Laundry & Linen Service	105,274					105,274	8
9	Housekeeping	347,224	2,516		2,694	107,629	460,063	9
10	Dietary	100,878	8,056		11,393	24,608	144,935	10
11	Cafeteria	232,584	2,585			92,787	327,956	11
12	Maintenance of Personnel							12
13	Nursing Administration	287,019	2,163		2,315	92,014	383,511	13
14	Central Services & Supply	48,575	3,757		4,022	11,066	67,420	14
15	Pharmacy	401,445	3,619		3,875	69,757	478,696	15
16	Medical Records & Library	542,233	28,355		30,360	146,877	747,825	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	1,196,566	52,626		56,346	616,257	1,921,795	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	516,341	35,041		37,518	131,041	719,941	50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,269,197	25,882		27,712	164,352	1,487,143	54
60	Laboratory	1,548,686	10,322		11,052	205,561	1,775,621	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	371,445	2,895		3,100	114,065	491,505	65
66	Physical Therapy	600,350		33,731	36,042	191,573	861,696	66
69	Electrocardiology	99,397	2,895		3,100	21,387	126,779	69
70	Electroencephalography	19,698	2,886		3,090	7,129	32,803	70
71	Medical Supplies Charged to Patients	406,155					406,155	71
72	Impl. Dev. Charged to Patients	48,794					48,794	72
73	Drugs Charged to Patients	496,536					496,536	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	494,003	22,246		23,819		540,068	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	3,784,414		130,063	138,975	1,321,988	5,375,440	88
90	Clinic	53,074				19,209	72,283	90
91	Emergency	1,996,276	24,081		25,784	316,868	2,363,009	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,089,699	10,718		11,476	331,240	1,443,133	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)	27,999,454	443,699	163,794	650,086	4,856,960	27,941,706	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,318		2,482		4,800	190
192	Physicians' Private Offices	34,919	11,373	9,583	22,417	9,575	87,867	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	28,034,373	457,390	173,377	674,985	4,866,535	28,034,373	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	6,074,536						5
6	Maintenance & Repairs							6
7	Operation of Plant	260,295	1,201,280					7
7.01	RHC UTILITY EXPENSE	13,224		61,028				7.01
8	Laundry & Linen Service	29,121			134,395			8
9	Housekeeping	127,263	11,883			599,209		9
10	Dietary	40,092	38,050			11,362	234,439	10
11	Cafeteria	90,719	12,209			3,646		11
12	Maintenance of Personnel							12
13	Nursing Administration	106,087	10,214			3,050		13
14	Central Services & Supply	18,650	17,743			5,298		14
15	Pharmacy	132,417	17,092			5,104		15
16	Medical Records & Library	206,863	133,928			39,993		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	531,607	248,564		134,395	74,225	234,439	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	199,150	165,507			49,423		50
53	Anesthesiology							53
54	Radiology-Diagnostic	411,373	122,248			36,505		54
60	Laboratory	491,172	48,753			14,558		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	135,960	13,674			4,083		65
66	Physical Therapy	238,362		11,873		47,478		66
69	Electrocardiology	35,070	13,674			4,083		69
70	Electroencephalography	9,074	13,633			4,071		70
71	Medical Supplies Charged to Patients	112,351						71
72	Impl. Dev. Charged to Patients	13,497						72
73	Drugs Charged to Patients	137,352						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	149,394	105,075			31,377		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	1,486,959		45,782		183,072		88
90	Clinic	19,995						90
91	Emergency	653,656	113,743			33,965		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	399,199	50,625			15,117		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)	6,048,902	1,136,615	57,655	134,395	566,410	234,439	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,328	10,947			3,269		190
192	Physicians' Private Offices	24,306	53,718	3,373		29,530		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	6,074,536	1,201,280	61,028	134,395	599,209	234,439	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	434,530						11
12	Maintenance of Personnel							12
13	Nursing Administration	10,606	513,468					13
14	Central Services & Supply	1,275	2,961	113,347				14
15	Pharmacy	8,040		1,393	642,742			15
16	Medical Records & Library	16,929				1,145,538		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	71,030	164,897	2,533		54,603	3,438,088	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,104	35,063	29,630		57,921	1,271,739	50
53	Anesthesiology							53
54	Radiology-Diagnostic	18,943	43,976	6,452		283,887	2,410,527	54
60	Laboratory	23,693	55,003	49,196		188,861	2,646,857	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,147	38,151	1,162		17,682	715,364	65
66	Physical Therapy	22,081		191		42,841	1,224,522	66
69	Electrocardiology	2,465		189		18,748	201,008	69
70	Electroencephalography	822				3,522	63,925	70
71	Medical Supplies Charged to Patients			7,473		70,553	596,532	71
72	Impl. Dev. Charged to Patients			4,477		920	67,688	72
73	Drugs Charged to Patients				642,742	125,326	1,401,956	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					18,863	844,777	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	152,376		5,362		85,608	7,334,599	88
90	Clinic	2,214				365	94,857	90
91	Emergency	36,522	84,786	3,686		123,990	3,413,357	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	38,179	88,631	1,570		51,848	2,088,302	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)	433,426	513,468	113,314	642,742	1,145,538	27,814,098	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						20,344	190
192	Physicians' Private Offices	1,104		33			199,931	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	434,530	513,468	113,347	642,742	1,145,538	28,034,373	202

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		3,438,088					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,271,739					50
53	Anesthesiology							53
54	Radiology-Diagnostic		2,410,527					54
60	Laboratory		2,646,857					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		715,364					65
66	Physical Therapy		1,224,522					66
69	Electrocardiology		201,008					69
70	Electroencephalography		63,925					70
71	Medical Supplies Charged to Patients		596,532					71
72	Impl. Dev. Charged to Patients		67,688					72
73	Drugs Charged to Patients		1,401,956					73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		844,777					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		7,334,599					88
90	Clinic		94,857					90
91	Emergency		3,413,357					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		2,088,302					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)		27,814,098					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		20,344					190
192	Physicians' Private Offices		199,931					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		28,034,373					202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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		199,601		213,714	413,315	413,315	5
6	Maintenance & Repairs							6
7	Operation of Plant		3,455		3,699	7,154	17,710	7
7.01	RHC UTILITY EXPENSE						900	7.01
8	Laundry & Linen Service						1,981	8
9	Housekeeping		2,516		2,694	5,210	8,659	9
10	Dietary		8,056		11,393	19,449	2,728	10
11	Cafeteria		2,585			2,585	6,172	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,163		2,315	4,478	7,218	13
14	Central Services & Supply		3,757		4,022	7,779	1,269	14
15	Pharmacy		3,619		3,875	7,494	9,010	15
16	Medical Records & Library		28,355		30,360	58,715	14,075	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		52,626		56,346	108,972	36,170	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		35,041		37,518	72,559	13,550	50
53	Anesthesiology							53
54	Radiology-Diagnostic		25,882		27,712	53,594	27,990	54
60	Laboratory		10,322		11,052	21,374	33,419	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,895		3,100	5,995	9,251	65
66	Physical Therapy			33,731	36,042	69,773	16,218	66
69	Electrocardiology		2,895		3,100	5,995	2,386	69
70	Electroencephalography		2,886		3,090	5,976	617	70
71	Medical Supplies Charged to Patients						7,644	71
72	Impl. Dev. Charged to Patients						918	72
73	Drugs Charged to Patients						9,345	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		22,246		23,819	46,065	10,165	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			130,063	138,975	269,038	101,181	88
90	Clinic						1,360	90
91	Emergency		24,081		25,784	49,865	44,474	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		10,718		11,476	22,194	27,161	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)		443,699	163,794	650,086	1,257,579	411,571	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,318		2,482	4,800	90	190
192	Physicians' Private Offices		11,373	9,583	22,417	43,373	1,654	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		457,390	173,377	674,985	1,305,752	413,315	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	24,864						7
7.01	RHC UTILITY EXPENSE		900					7.01
8	Laundry & Linen Service			1,981				8
9	Housekeeping	246			14,115			9
10	Dietary	788			268	23,233		10
11	Cafeteria	253			86		9,096	11
12	Maintenance of Personnel							12
13	Nursing Administration	211			72		222	13
14	Central Services & Supply	367			125		27	14
15	Pharmacy	354			120		168	15
16	Medical Records & Library	2,772			942		354	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	5,144		1,981	1,748	23,233	1,486	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,426			1,164		316	50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,530			860		396	54
60	Laboratory	1,009			343		496	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	283			96		275	65
66	Physical Therapy		175		1,118		462	66
69	Electrocardiology	283			96		52	69
70	Electroencephalography	282			96		17	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	2,175			739			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		675		4,313		3,193	88
90	Clinic						46	90
91	Emergency	2,354			800		764	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,048			356		799	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)	23,525	850	1,981	13,342	23,233	9,073	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	227			77			190
192	Physicians' Private Offices	1,112	50		696		23	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,864	900	1,981	14,115	23,233	9,096	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	12,201						13
14	Central Services & Supply	70	9,637					14
15	Pharmacy		118	17,264				15
16	Medical Records & Library				76,858			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	3,919	215		3,664	186,532		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	833	2,519		3,886	98,253		50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,045	549		19,044	106,008		54
60	Laboratory	1,307	4,183		12,672	74,803		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	906	99		1,186	18,091		65
66	Physical Therapy		16		2,874	90,636		66
69	Electrocardiology		16		1,258	10,086		69
70	Electroencephalography				236	7,224		70
71	Medical Supplies Charged to Patients		635		4,734	13,013		71
72	Impl. Dev. Charged to Patients		381		62	1,361		72
73	Drugs Charged to Patients			17,264	8,409	35,018		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				1,266	60,410		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		456		5,744	384,600		88
90	Clinic				25	1,431		90
91	Emergency	2,015	313		8,319	108,904		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	2,106	134		3,479	57,277		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)	12,201	9,634	17,264	76,858	1,253,647		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					5,194		190
192	Physicians' Private Offices		3			46,911		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	12,201	9,637	17,264	76,858	1,305,752		202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	186,532						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	98,253						50
53	Anesthesiology							53
54	Radiology-Diagnostic	106,008						54
60	Laboratory	74,803						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,091						65
66	Physical Therapy	90,636						66
69	Electrocardiology	10,086						69
70	Electroencephalography	7,224						70
71	Medical Supplies Charged to Patients	13,013						71
72	Impl. Dev. Charged to Patients	1,361						72
73	Drugs Charged to Patients	35,018						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	60,410						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	384,600						88
90	Clinic	1,431						90
91	Emergency	108,904						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	57,277						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)	1,253,647						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,194						190
192	Physicians' Private Offices	46,911						192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,305,752						202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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				13,446,401			4
5	Administrative & General	23,167		23,167	2,101,580	-6,074,536	21,959,837	5
6	Maintenance & Repairs							6
7	Operation of Plant	401		401	306,547		940,985	7
7.01	RHC UTILITY EXPENSE						47,804	7.01
8	Laundry & Linen Service						105,274	8
9	Housekeeping	292		292	297,383		460,063	9
10	Dietary	935		1,235	67,993		144,935	10
11	Cafeteria	300			256,375		327,956	11
12	Maintenance of Personnel							12
13	Nursing Administration	251		251	254,239		383,511	13
14	Central Services & Supply	436		436	30,576		67,420	14
15	Pharmacy	420		420	192,742		478,696	15
16	Medical Records & Library	3,291		3,291	405,825		747,825	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	1,702,738		1,921,795	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067		4,067	362,070		719,941	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004		3,004	454,110		1,487,143	54
60	Laboratory	1,198		1,198	567,973		1,775,621	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336		336	315,165		491,505	65
66	Physical Therapy		3,907	3,907	529,323		861,696	66
69	Electrocardiology	336		336	59,093		126,779	69
70	Electroencephalography	335		335	19,698		32,803	70
71	Medical Supplies Charged to Patients						406,155	71
72	Impl. Dev. Charged to Patients						48,794	72
73	Drugs Charged to Patients						496,536	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582		2,582			540,068	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	3,652,699		5,375,440	88
90	Clinic				53,074		72,283	90
91	Emergency	2,795		2,795	875,517		2,363,009	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244		1,244	915,226		1,443,133	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	13,419,946	-6,074,536	21,867,170	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269		269			4,800	190
192	Physicians' Private Offices	1,320	1,110	2,430	26,455		87,867	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	457,390	173,377	674,985	4,866,535		6,074,536	202
203	Unit Cost Multiplier (Wkst. B, Part I)	8.615857	8.633453	9.225013	0.361921		0.276620	203
204	Cost to be allocated (Per Wkst. B, Part II)						413,315	204
205	Unit Cost Multiplier (Wkst. B, Part II)						0.018821	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206

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	
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	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		10,416,523	11
12	Maintenance of Personnel							12
13	Nursing Administration	251			251		254,239	13
14	Central Services & Supply	436			436		30,576	14
15	Pharmacy	420			420		192,742	15
16	Medical Records & Library	3,291			3,291		405,825	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	1,702,738	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067			4,067		362,070	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004			3,004		454,110	54
60	Laboratory	1,198			1,198		567,973	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336			336		315,165	65
66	Physical Therapy		3,907		3,907		529,323	66
69	Electrocardiology	336			336		59,093	69
70	Electroencephalography	335			335		19,698	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		3,652,699	88
90	Clinic						53,074	90
91	Emergency	2,795			2,795		875,517	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244			1,244		915,226	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	10,390,068	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269			269			190
192	Physicians' Private Offices	1,320	1,110		2,430		26,455	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,201,280	61,028	134,395	599,209	234,439	434,530	202
203	Unit Cost Multiplier (Wkst. B, Part I)	40.695145	3.038940	48.135745	12.152122	83.968123	0.041715	203
204	Cost to be allocated (Per Wkst. B, Part II)	24,864	900	1,981	14,115	23,233	9,096	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.842305	0.044816	0.709527	0.286256	8.321275	0.000873	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	5,302,166						13
14	Central Services & Supply	30,576	1,235,425					14
15	Pharmacy		15,184	435,822				15
16	Medical Records & Library				71,565,193			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	1,702,738	27,607		3,411,222			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	362,070	322,948		3,618,472			50
53	Anesthesiology							53
54	Radiology-Diagnostic	454,110	70,328		17,735,538			54
60	Laboratory	567,973	536,209		11,798,626			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	393,956	12,662		1,104,672			65
66	Physical Therapy		2,082		2,676,411			66
69	Electrocardiology		2,056		1,171,241			69
70	Electroencephalography				220,000			70
71	Medical Supplies Charged to Patients		81,457		4,407,664			71
72	Impl. Dev. Charged to Patients		48,794		57,454			72
73	Drugs Charged to Patients			435,822	7,829,430			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				1,178,420			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		58,442		5,348,151			88
90	Clinic				22,818			90
91	Emergency	875,517	40,178		7,745,979			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	915,226	17,114		3,239,095			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)	5,302,166	1,235,061	435,822	71,565,193			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		364					192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	513,468	113,347	642,742	1,145,538			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.096841	0.091747	1.474781	0.016007			203
204	Cost to be allocated (Per Wkst. B, Part II)	12,201	9,637	17,264	76,858			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.002301	0.007801	0.039613	0.001074			205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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			
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	3,438,088		3,438,088			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,271,739		1,271,739			50
53	Anesthesiology						53
54	Radiology-Diagnostic	2,410,527		2,410,527			54
60	Laboratory	2,646,857		2,646,857			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	715,364		715,364			65
66	Physical Therapy	1,224,522		1,224,522			66
69	Electrocardiology	201,008		201,008			69
70	Electroencephalography	63,925		63,925			70
71	Medical Supplies Charged to Patients	596,532		596,532			71
72	Impl. Dev. Charged to Patients	67,688		67,688			72
73	Drugs Charged to Patients	1,401,956		1,401,956			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	844,777		844,777			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	7,334,599		7,334,599			88
90	Clinic	94,857		94,857			90
91	Emergency	3,413,357		3,413,357			91
92	Observation Beds (Non-Distinct Part)	245,106		245,106			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	2,088,302		2,088,302			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)	28,059,204		28,059,204			200
201	Less Observation Beds	245,106		245,106			201
202	Total (line 200 minus line 201)	27,814,098		27,814,098			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	2,100,821		2,100,821				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	492,344	3,126,128	3,618,472	0.351457			50
53	Anesthesiology							53
54	Radiology-Diagnostic	784,904	16,950,634	17,735,538	0.135915			54
60	Laboratory	1,232,186	10,566,440	11,798,626	0.224336			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	778,478	326,194	1,104,672	0.647580			65
66	Physical Therapy	529,124	2,147,287	2,676,411	0.457524			66
69	Electrocardiology	50,546	1,120,695	1,171,241	0.171620			69
70	Electroencephalography		220,000	220,000	0.290568			70
71	Medical Supplies Charged to Patients	2,630,329	1,777,335	4,407,664	0.135340			71
72	Impl. Dev. Charged to Patients	23,160	34,294	57,454	1.178125			72
73	Drugs Charged to Patients	3,122,463	4,706,967	7,829,430	0.179062			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1,178,420	1,178,420	0.716873			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		5,348,151	5,348,151				88
90	Clinic		22,818	22,818	4.157113			90
91	Emergency	195,099	7,550,880	7,745,979	0.440662			91
92	Observation Beds (Non-Distinct Part)	4,000	1,306,401	1,310,401	0.187047			92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		3,239,095	3,239,095	0.644718			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)	11,943,454	59,621,739	71,565,193				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	11,943,454	59,621,739	71,565,193				202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed 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	0.351457		1,456,761			511,989		50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.135915		7,075,307			961,640		54
60	Laboratory	0.224336		4,894,785			1,098,076		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.647580		175,975			113,958		65
66	Physical Therapy	0.457524		759,015			347,268		66
69	Electrocardiology	0.171620		593,049			101,779		69
70	Electroencephalography	0.290568		219,295			63,720		70
71	Medical Supplies Charged to Pat	0.135340		970,276			131,317		71
72	Impl. Dev. Charged to Patients	1.178125		33,530			39,503		72
73	Drugs Charged to Patients	0.179062		2,183,088			390,908		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.716873		1,155,953			828,671		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	4.157113		20,228			84,090		90
91	Emergency	0.440662		2,677,840			1,180,022		91
92	Observation Beds (Non-Distinct	0.187047		535,490			100,162		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.644718							95
200	Subtotal (see instructions)			22,750,592			5,953,103		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			22,750,592			5,953,103		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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 Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.351457							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.135915							54
60	Laboratory	0.224336							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.647580							65
66	Physical Therapy	0.457524							66
69	Electrocardiology	0.171620							69
70	Electroencephalography	0.290568							70
71	Medical Supplies Charged to Pat	0.135340							71
72	Impl. Dev. Charged to Patients	1.178125							72
73	Drugs Charged to Patients	0.179062							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.716873							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	4.157113							90
91	Emergency	0.440662							91
92	Observation Beds (Non-Distinct	0.187047							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.644718							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)	186,532	44,844	141,688	2,376	59.63	187	11,151	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)	186,532		141,688	2,376		187	11,151	200

(A) Worksheet A line numbers

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	98,253	3,618,472	0.027153			50
53	Anesthesiology						53
54	Radiology-Diagnostic	106,008	17,735,538	0.005977			54
60	Laboratory	74,803	11,798,626	0.006340			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,091	1,104,672	0.016377			65
66	Physical Therapy	90,636	2,676,411	0.033865			66
69	Electrocardiology	10,086	1,171,241	0.008611			69
70	Electroencephalography	7,224	220,000	0.032836			70
71	Medical Supplies Charged to Pat	13,013	4,407,664	0.002952			71
72	Impl. Dev. Charged to Patients	1,361	57,454	0.023689			72
73	Drugs Charged to Patients	35,018	7,829,430	0.004473			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	60,410	1,178,420	0.051264			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	384,600	5,348,151	0.071913			88
90	Clinic	1,431	22,818	0.062714			90
91	Emergency	108,904	7,745,979	0.014059			91
92	Observation Beds (Non-Distinct	13,298	1,310,401	0.010148			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,023,136	66,225,277				200

(A) Worksheet A line numbers

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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX
[ ] PPS
[ ] TEFRA
[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)	2,376		187		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)	2,376		187		200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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**

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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

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

Check Applicable Boxes: **[ ] Title V** **[ ] 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	3,618,472							50
53	Anesthesiology								53
54	Radiology-Diagnostic	17,735,538							54
60	Laboratory	11,798,626							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,104,672							65
66	Physical Therapy	2,676,411							66
69	Electrocardiology	1,171,241							69
70	Electroencephalography	220,000							70
71	Medical Supplies Charged to Pat	4,407,664							71
72	Impl. Dev. Charged to Patients	57,454							72
73	Drugs Charged to Patients	7,829,430							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1,178,420							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	5,348,151							88
90	Clinic	22,818							90
91	Emergency	7,745,979							91
92	Observation Beds (Non-Distinct	1,310,401							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	66,225,277							200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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 Reimbursed Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Subject to Ded. & Coins. (see inst.)	Cost Reimbursed 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	0.351457							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.135915							54
60	Laboratory	0.224336							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.647580							65
66	Physical Therapy	0.457524							66
69	Electrocardiology	0.171620							69
70	Electroencephalography	0.290568							70
71	Medical Supplies Charged to Pat	0.135340							71
72	Impl. Dev. Charged to Patients	1.178125							72
73	Drugs Charged to Patients	0.179062							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.716873							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	4.157113							90
91	Emergency	0.440662							91
92	Observation Beds (Non-Distinct	0.187047							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.644718							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

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)	3,128	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,376	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)	2,153	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	627	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)	125	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)	1,476	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)	627	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)	125	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)	3,438,088	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)	826,546	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,611,542	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,611,542	37

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)					1,099.13	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,622,316	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,622,316	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)					1,252,059	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,874,375	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)					689,155	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					137,391	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					826,546	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

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)					223	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,099.13	88
89	Observation bed cost (line 87 x line 88) (see instructions)					245,106	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	186,532	3,438,088	0.054255	245,106	13,298	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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)	3,128	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,376	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)	2,153	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	627	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)	125	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)	187	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)	3,438,088	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)	826,546	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,611,542	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,611,542	37

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** **[XX] 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)					1,099.13	38
39	Program general inpatient routine service cost (line 9 x line 38)					205,537	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)					205,537	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)					205,537	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					11,151	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)					11,151	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] Title XVIII, Part A** **[XX] Title XIX - I/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/IID** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					223	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: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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		1,403,820		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.351457	304,222	106,921	50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.135915	333,107	45,274	54
60	Laboratory	0.224336	735,962	165,103	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.647580	491,923	318,559	65
66	Physical Therapy	0.457524	151,204	69,179	66
69	Electrocardiology	0.171620	36,990	6,348	69
70	Electroencephalography	0.290568			70
71	Medical Supplies Charged to Patients	0.135340	1,700,699	230,173	71
72	Impl. Dev. Charged to Patients	1.178125	19,270	22,702	72
73	Drugs Charged to Patients	0.179062	1,570,685	281,250	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.716873			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	4.157113			90
91	Emergency	0.440662	13,778	6,071	91
92	Observation Beds (Non-Distinct Part)	0.187047	2,563	479	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		5,360,403	1,252,059	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,360,403		202

(A) Worksheet A line numbers

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.351457			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.135915	15,274	2,076	54
60	Laboratory	0.224336	164,215	36,839	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.647580	166,654	107,922	65
66	Physical Therapy	0.457524	358,579	164,058	66
69	Electrocardiology	0.171620	6,536	1,122	69
70	Electroencephalography	0.290568			70
71	Medical Supplies Charged to Patients	0.135340	490,754	66,419	71
72	Impl. Dev. Charged to Patients	1.178125			72
73	Drugs Charged to Patients	0.179062	464,757	83,220	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.716873			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	4.157113			90
91	Emergency	0.440662	895	394	91
92	Observation Beds (Non-Distinct Part)	0.187047	1,256	235	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		1,668,920	462,285	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,668,920		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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

		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				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.351457			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.135915			54
60	Laboratory	0.224336			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.647580			65
66	Physical Therapy	0.457524			66
69	Electrocardiology	0.171620			69
70	Electroencephalography	0.290568			70
71	Medical Supplies Charged to Patients	0.135340			71
72	Impl. Dev. Charged to Patients	1.178125			72
73	Drugs Charged to Patients	0.179062			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.716873			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	4.157113			90
91	Emergency	0.440662			91
92	Observation Beds (Non-Distinct Part)	0.187047			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)	5,953,103			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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)	5,953,103			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 (see instructions)	6,012,634			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, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	45,379			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,557,497			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)	2,409,758			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)	2,409,758			30
31	Primary payer payments	1,509			31
32	Subtotal (line 30 minus line 31)	2,408,249			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)	423,420			34
35	Adjusted reimbursable bad debts (see instructions)	275,223			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	423,420			36
37	Subtotal (see instructions)	2,683,472			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)	2,683,472			40
40.01	Sequestration adjustment (see instructions)	53,669			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,657,233			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-27,430			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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				2,599,735		2,876,684	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	02/22/2018	3,550			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	10/19/2017	401,231	10/19/2017	184,976	3.50
			.51			02/22/2018	34,475	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		-397,681		-219,451	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)				2,202,054		2,657,233	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		359,748			6.01
	based on the cost report (1)		.02				-27,430	6.02
7	Total Medicare program liability (see instructions)				2,561,802		2,629,803	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.

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,150,587			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					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					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)				1,150,587			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		124,775			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,275,362			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.

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)	834,811		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)	466,908		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	752		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)	1,301,719		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,301,719		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,301,719		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	329		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)	1,301,390		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)	1,301,390		19
19.01	Sequestration adjustment (see instructions)	26,028		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	1,150,587		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	124,775		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	2,874,375	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,874,375	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,903,119	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)	2,903,119	19
20	Deductibles (exclude professional component)	303,787	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,599,332	22
23	Coinsurance	2,303	23
24	Subtotal (line 22 minus line 23)	2,597,029	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	26,238	25
26	Adjusted reimbursable bad debts (see instructions)	17,055	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	26,238	27
28	Subtotal (sum of lines 24 and 26)	2,614,084	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,614,084	30
30.01	Sequestration adjustment (see instructions)	52,282	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	2,202,054	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	359,748	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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	205,537		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	205,537		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	205,537		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)	205,537		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)	205,537		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)	205,537		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)	205,537		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	205,537		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)	205,537		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	205,537		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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	3,766,865				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	4,837,946				4
5	Other receivables	1,015,860				5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	215,061				7
8	Prepaid expenses	780,291				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,616,023				11
	FIXED ASSETS					
12	Land	135,111				12
13	Land improvements	351,668				13
14	Accumulated depreciation	-307,070				14
15	Buildings	13,269,019				15
16	Accumulated depreciation	-10,283,894				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	8,356,168				19
20	Accumulated depreciation	-6,541,210				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	-1,515,211				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	5,038,911				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	3,699,559				34
35	Total other assets (sum of lines 31-34)	3,699,559				35
36	Total assets (sum of lines 11, 30 and 35)	19,354,493				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	814,748				37
38	Salaries, wages and fees payable	1,181,733				38
39	Payroll taxes payable	28,603				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	1,297,034				44
45	Total current liabilities (sum of lines 37 thru 44)	3,322,118				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	830,800				47
48	Unsecured loans					48
49	Other long term liabilities	4,432,616				49
50	Total long term liabilities (sum of lines 46 thru 49)	5,263,416				50
51	Total liabilities (sum of lines 45 and 50)	8,585,534				51
	CAPITAL ACCOUNTS					
52	General fund balance	10,768,959				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: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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)	10,768,959				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	19,354,493				60

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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		11,145,068			1
2	Net income (loss) (from Worksheet G-3, line 29)		-376,109			2
3	Total (sum of line 1 and line 2)		10,768,959			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)		10,768,959			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)		10,768,959			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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	2,100,821		2,100,821	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	270,535		270,535	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)	2,371,356		2,371,356	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)	2,371,356		2,371,356	17
18	Ancillary services	10,021,698		10,021,698	18
19	Outpatient services		52,133,202	52,133,202	19
20	Rural Health Clinic (RHC)		5,488,711	5,488,711	20
20.01	RHC II				20.01
20.02	RHC III				20.02
20.03	RHC IV				20.03
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance		3,239,095	3,239,095	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)	12,393,054	60,861,008	73,254,062	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		31,679,996	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)		31,679,995	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	73,254,062	1
2	Less contractual allowances and discounts on patients' accounts	44,668,429	2
3	Net patient revenues (line 1 minus line 2)	28,585,633	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	31,679,995	4
5	Net income from service to patients (line 3 minus line 4)	-3,094,362	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	247,338	6
7	Income from investments	11,706	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	147,789	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	7,771	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)	205,332	24
24.01	Other (RENTAL INCOME)	78,053	24.01
24.02	Other (MISCELLANEOUS INCOME)	107,245	24.02
24.03	Other (GRANT INCOME)	233,480	24.03
24.04	Other (EHR INCENTIVE)	110,500	24.04
24.05	Other (340B PROGRAM REVENUE)	1,569,039	24.05
24.06	Other (SALE OF EQUIPMENT)		24.06
25	Total other income (sum of lines 6-24)	2,718,253	25
26	Total (line 5 plus line 25)	-376,109	26
27.01	Other expenses (LOSS ON INVESTMENTS)		27.01
29	Net income (or loss) for the period (line 26 minus line 28)	-376,109	29

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	825,626		825,626		825,626	-72,000	753,626	1
2	Physician Assistant								2
3	Nurse Practitioner	866,212		866,212		866,212	-167,000	699,212	3
4	Visiting Nurse								4
5	Other Nurse	724,343		724,343		724,343		724,343	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	67,787		67,787		67,787		67,787	9
10	Subtotal (sum of lines 1 through 9)	2,483,968		2,483,968		2,483,968	-239,000	2,244,968	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		105,250	105,250		105,250	-96,250	9,000	11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement		120,851	120,851		120,851		120,851	13
14	Subtotal (sum of lines 11 through 13)		226,101	226,101		226,101	-96,250	129,851	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		55,592	55,592		55,592		55,592	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		1,093	1,093		1,093		1,093	18
19	Other Health Care Costs		194,108	194,108		194,108	-9,929	184,179	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		250,793	250,793		250,793	-9,929	240,864	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,483,968	476,894	2,960,862		2,960,862	-345,179	2,615,683	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	1,221,805		1,221,805	-53,074	1,168,731		1,168,731	29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)	1,221,805		1,221,805	-53,074	1,168,731		1,168,731	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	3,705,773	476,894	4,182,667	-53,074	4,129,593	-345,179	3,784,414	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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	1.80	8,049	4,200	7,560		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	4.69	19,680	2,100	9,849		3
4	Subtotal (sum of lines 1 through 3)	6.49	27,729		17,409	27,729	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)	6.49	27,729			27,729	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)	2,615,683	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)	2,615,683	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)	1,168,731	14
15	Parent provider overhead allocated to facility (see instructions)	3,550,185	15
16	Total overhead (sum of lines 14 and 15)	4,718,916	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	4,718,916	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	4,718,916	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	7,334,599	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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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)	7,334,599	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	81,613	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	7,252,986	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	27,729	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	27,729	6
7	Adjusted cost per visit (line 3 divided by line 6)	261.57	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)	261.57	261.57	261.57	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		6,030		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,577,267		11
12	Program covered visits for mental health services (from contractor records)		14		12
13	Program covered cost from mental health services (line 9 x line 12)		3,662		13
14	Limit adjustment for mental health services (see instructions)		3,662		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,580,929		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)		1,191,295		16.04
16.05	Total program cost (see instructions)		1,191,295		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		91,810		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		174,749		19
20	Net Medicare cost excluding vaccines (see instructions)		1,191,295		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		62,757		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,254,052		22
23	Allowable bad debts (see instructions)		85,326		23
23.01	Adjusted reimbursable bad debts (see instructions)		55,462		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)		1,309,514		26
26.01	Sequestration adjustment (see instructions)		26,190		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		939,563		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		343,761		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.

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)	2,244,968	2,244,968	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000864	0.001580	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,940	3,547	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	19,522	4,096	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	21,462	7,643	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,615,683	2,615,683	6
7	Total overhead (from Wkst. M-2, line 16)	4,718,916	4,718,916	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008205	0.002922	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	38,719	13,789	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	60,181	21,432	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	140	256	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	429.86	83.72	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	116	154	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	49,864	12,893	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)		81,613	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)		62,757	16

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form **CMS-2552-10**	Period : From: 03/01/2017 To: 02/28/2018	Run Date: 07/27/2018 Run Time: 15:01 Version: 2018.04 (07/10/2018)

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	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				975,348	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			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	10/19/2017	35,785	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		-35,785	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				939,563	
	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		343,761	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				1,283,324	
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.