

CLAY COUNTY HOSPITAL
FLORA, ILLINOIS
MEDICARE COST REPORT
YEAR ENDED FEBRUARY 28, 2009

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

WORKSHEET S
 PARTS I & II

INTERMEDIARY [] AUDITED DATE RECEIVED [] INITIAL [] RE-OPENING
 USE ONLY: [] DESK REVIEWED INTERMEDIARY NO. [] FINAL [] MCR CODE

PART I - CERTIFICATION

CHECK DATE: 07/02/2009
 APPLICABLE BOX XX ELECTRONICALLY FILED COST REPORT TIME: 11:24
 MANUALLY SUBMITTED COST REPORT

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 03/01/2008 AND ENDING 02/28/2009, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 07/02/2009 11:24
 FuDBpuogknoKwjfGOEDsdRlGyn8930
 muveq04bQ0Dbl8hT.1JZCrtUFEgGau
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(SIGNED)

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PI Encryption: 07/02/2009 11:24
 M8HjRejx9.TvLhsWQ71DY3JPrvg1y0
 nZt1g0cZiv8UsqeaLuqm159UD5q:w0
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PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	424988	172698	7600	1
2	SUBPROVIDER I				2
3	SWING BED - SNF	14297			3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	RURAL HEALTH CLINIC I		264431		9
9.01	RURAL HEALTH CLINIC II				9.01
100	TOTAL	439285	437129	7600	100

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND 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 657 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: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.06
26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:			26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.			26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:			26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	01/25/1985	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.			28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st			28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.			28.02
<p>A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 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. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)</p>				
28.03	STAFFING	0.00	N	28.03
28.04	RECRUITMENT	0.00	N	28.04
28.05	RETENTION OF EMPLOYEES	0.00	N	28.05
28.06	TRAINING	0.00	N	28.06
28.07	OTHER (SPECIFY)			28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO		29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES		30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO		30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO		30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO		30.03
30.04	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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D 2, PART II.	NO		30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO		31

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

MISCELLANEOUS COST REPORTING INFORMATION

32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO			32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO			33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO			34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35

		V	XVIII	XIX	
		1	2	3	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	NO	NO	36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01

TITLE XIX INPATIENT HOSPITAL SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	YES			38
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	NO			38.01
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	NO			38.02
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	NO			38.03
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	NO			38.04
40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.	NO			40
40.01	NAME:	FI/CONTRACTOR'S NAME:	FI/CONTRACTOR'S NUMBER:		40.01
40.02	STREET:		P.O. BOX:		40.02
40.03	CITY:		STATE:	ZIP CODE:	40.03
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	YES			41
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	YES			42
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42.01
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	NO			42.02
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS?	NO			43
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY?	NO			44
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.	NO			45
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?				45.01
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?				45.02
45.03	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD?				45.03
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE.				46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

	PART A	PART B	ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47	HOSPITAL	N	N	N	N	47
48	SUBPROVIDER I	N	N	N	N	48
49	SKILLED NURSING FACILITY	N	N			49
50	HOME HEALTH AGENCY	N	N			50

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?	NO			52
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.	NO			52.01
53	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				53
53.01	MDH PERIOD: BEGINNING: ENDING:				53.01
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 250138 PAID LOSSES: AND/OR SELF INSURANCE:				54
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	YES			54.01
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.	NO			55

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

		DATE	Y/N	LIMIT	Y/N	FEE\$	
		0	1	2	3	4	
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.	/ /	NO	0.00	NO		56
57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?		NO				57
58	ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.		NO				58
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				59
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)		NO				60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES 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. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)						60.01
MULTICAMPUS							
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.		NO				61
	COUNTY:	STATE:	ZIP CODE	CBSA	FTE/ CAMPUS		
	1	2	3	4	5		
SETTLEMENT DATA							
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		NO				63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS	
	TITLE	TITLE	TITLE			
	V	XVIII	XIX			
	12	13	14	15		
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		802	132	1139	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		802	132	1139	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
24.01	RHC II					24.01
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II

PART II - WAGE DATA

	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	
	1	2	3	4	5	6	
SALARIES							
1 TOTAL SALARIES	6285480			324493.00			1
2 NON-PHYSICIAN ANESTHETIST PART A	45						2
3 NON-PHYSICIAN ANESTHETIST PART B							3
4 PHYSICIAN - PART A							4
4.01 TEACHING PHYSICIAN SALARIES							4.01
5 PHYSICIAN - PART B	901552			38780.00			5
5.01 NON-PHYSICIAN - PART B							5.01
6 INTERNS & RESIDENTS (IN APPR PGM)							6
6.01 CONTRACT SERVICES, I&R							6.01
7 HOME OFFICE PERSONNEL							7
8 SNF							8
8.01 EXCLUDED AREA SALARIES	367271						8.01
OTHER WAGES & RELATED COSTS							
9 CONTRACT LABOR	1294437						9
9.01 PHARMACY SERVICES UNDER CONTRACT							9.01
9.02 LABORATORY SERVICES UNDER CONTRACT							9.02
9.03 MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10 CONTRACT LABOR: PHYSICIAN PART A							10
10.01 TEACHING PHYSICIAN UNDER CONTRACT							10.01
11 HOME OFFICE SALARIES & WAGE REL COSTS							11
12 HOME OFFICE: PHYSICIAN PART A							12
12.01 TEACHING PHYSICIAN SALARIES							12.01
WAGE-RELATED COSTS							
13 WAGE RELATED COSTS (CORE)	1455267					CMS 339	13
14 WAGE RELATED COSTS (OTHER)						CMS 339	14
15 EXCLUDED AREAS	110574					CMS 339	15
16 NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17 NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18 PHYSICIAN PART A						CMS 339	18
18.01 PART A TEACHING PHYSICIANS						CMS 339	18.01
19 PHYSICIAN PART B						CMS 339	19
19.01 WAGE RELATED COSTS (RHC/FQHC)	279914						19.01
20 INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
OVERHEAD COSTS - DIRECT SALARIES							
21 EMPLOYEE BENEFITS	76756			4018.00			21
22 ADMINISTRATIVE & GENERAL	614279			42342.00			22
22.01 ADMINISTRATIVE & GENERAL UNDER CONTACT	305980						22.01
23 MAINTENANCE & REPAIRS							23
24 OPERATION OF PLANT	134439			6948.00			24
25 LAUNDRY & LINEN SERVICE							25
26 HOUSEKEEPING	173784			18173.00			26
26.01 HOUSEKEEPING UNDER CONTRACT							26.01
27 DIETARY	155017			15474.00			27
27.01 DIETARY UNDER CONTRACT	5733						27.01
28 CAFETERIA							28
29 MAINTENANCE OF PERSONNEL							29
30 NURSING ADMINISTRATION	174083			2181.00			30
31 CENTRAL SERVICES AND SUPPLY	20626			2077.00			31
32 PHARMACY	150917			4255.00			32
33 MEDICAL RECORDS & MEDICAL RECORDS LIBR	233954			16567.00			33
34 SOCIAL SERVICE							34
35 OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART III

	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST. A-6	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	
	1	2	3	4	5	
PART III - HOSPITAL WAGE INDEX SUMMARY						
1 NET SALARIES	5695596		5695596	285713.00	19.93	1
2 EXCLUDED AREA SALARIES	367271		367271			2
3 SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	5328325		5328325	285713.00	18.65	3
4 SUBTOTAL OTHER WAGES & REL COSTS	1294437		1294437			4
5 SUBTOTAL WAGE-RELATED COSTS	1455267		1455267		27.31%	5
6 TOTAL (SUM OF LINES 3 THRU 5)	8078029		8078029	285713.00	28.27	6
7 NET SALARIES						7
8 EXCLUDED AREA SALARIES						8
9 SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10 SUBTOTAL OTHER WAGES & REL COSTS						10
11 SUBTOTAL WAGE-RELATED COSTS						11
12 TOTAL (SUM OF LINES 9 THRU 11)						12
13 TOTAL OVERHEAD COSTS	2045568		2045568	112035.00	18.26	13

NHCMQ DEMONSTRATION STATISTICAL DATA
 STATISTICAL DATA

WORKSHEET S-7

GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1		SERVICES ON OR AFTER JANUARY 1		TOTAL
		RATE	DAYS	RATE	DAYS	
1	2	3	3.01	4	4.01	5
1	RVC/RUC					1
2	RVB/RUB					2
3	RVA/RUA					3
3.01	RUX					3.01
3.02	RUL					3.02
4	RHD/RVC					4
5	RHC/RVB					5
6	RHB/RVA					6
6.01	RVX					6.01
6.02	RVL					6.02
7	RHA/RHC					7
8	RMC/RHB					8
9	RMB/RHA					9
9.01	RHX					9.01
9.02	RHL					9.02
10	RMA/RMC					10
11	RLB/RMB					11
12	RLA/RMA					12
12.01	RMX					12.01
12.02	RML					12.02
13	SE3/RLB					13
14	SE2/RLA					14
14.01	RLX					14.01
15	SE1/SE3					15
16	SSC/SE2					16
17	SSB/SE1					17
18	SSA/SSC					18
19	CD2/SSB					19
20	CD1/SSA					20
21	CC2					21
22	CC1					22
23	CB2					23
24	CB1					24
25	CA2					25
26	CA1					26
27	IB2					27
28	IB1					28
29	IA2					29
30	IA1					30
31	BB2					31
32	BB1					32
33	BA2					33
34	BA1					34
35	PE2					35
36	PE1					36
37	PD2					37
38	PD1					38
39	PC2					39
40	PC1					40
41	PB2					41
42	PB1					42
43	PA2					43
44	PA1					44
45	DEFAULT RATE					45
46	TOTAL					46

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2008 TO 02/28/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01
 07/02/2009 09:11

RHC I
 COMPONENT NO: 14-3458

WORKSHEET S-8

PROVIDER-BASED RURAL HEALTH CLINIC/
 FEDERALLY QUALIFIED HEALTH CENTER
 PROVIDER STATISTICAL DATA

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 929 STACY BURK DRIVE 1
 1.01 CITY: FLORA STATE: IL ZIP CODE: 62839 COUNTY: CLAY 1.01
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

	GRANT AWARD	DATE		
		1	2	
3 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)		/	/	3
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/	/	4
5 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)		/	/	5
6 APPALACHIAN REGIONAL COMMISSION		/	/	6
7 LOOK-ALIKES		/	/	7
8 OTHER		/	/	8

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NO.	
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT	WYNN, MD	1356310468	9
9.01	KLINGLER	1447450085	9.01
9.02	GALEN F LUEKING, MD	1235150343	9.02
9.03	JENNIFER MANEJA, MD	1194775064	9.03
9.04	JANES	1982629333	9.04
9.05	ERXLEBEN	1497770234	9.05
9.06	KNIGHT	1992959282	9.06

	PHYSICIAN NAME	HOURS	
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD	ALDEN JALLORINA, MD	40.00	10
10.01	GALEN F LUEKING, MD	40.00	10.01
10.02	HEIDI DE LA ROSA, MD	40.00	10.02
10.03	JENNIFER MANEJA, MD	40.00	10.03

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11
 IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2
 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO
12 CLINIC	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
				800	1700	800	1700	800	1700	800	1700	800	1700		

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS 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.

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? NO 13
 14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? YES 2 14
 IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.

15 PROVIDER NAME: CLAY COUNTY HOSPITAL CLIN PROVIDER NUMBER: 14-3458 15
 15.01 LOUISVILLE MEDICAL CLINIC 14-3487 15.01
 V XVIII XIX

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16
 17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. NO 17
 IF YES, SEE INSTRUCTIONS.

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSI- FICATIONS	RECLASS. TRIAL BALANCE	ADJUST- MENTS	NET EXP FOR ALLOCATION	
		1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS									
1	0100								1
2	0200								2
3	0300		1035182	1035182	-179483	855699	-276110	579589	3
3.01	0301		19645	19645	173604	193249		193249	3.01
4	0400		721821	721821	5879	727700		727700	4
5	0500	76756	2897712	2974468		2974468	-142530	2831938	5
6	0600	614279	1072113	1686392	-13877	1672515	-115661	1556854	6
7	0700								7
8	0800								8
8.01	0801	134439	352434	486873		486873		486873	8.01
9	0900		26931	26931		26931		26931	9
10	1000		70992	70992		70992		70992	10
11	1100	173784	41100	214884		214884		214884	11
12	1200	155017	134037	289054		289054	-92294	196760	12
13	1300								13
14	1400								14
15	1500	174083	15147	189230		189230		189230	15
16	1600	20626	1443	22069		22069		22069	16
17	1700	150917	3590	154507		154507		154507	17
18	1800	233954	42684	276638		276638	-4429	272209	18
20	2000								20
21	2100								21
22	2200								22
23	2300								23
24	2400								24
INPATIENT ROUTINE SERV COST CENTERS									
25	2500	894388	32454	926842		926842		926842	25
ANCILLARY SERVICE COST CENTERS									
37	3700	377645	129713	507358	13606	520964		520964	37
40	4000	45	261842	261887	-13606	248281	-248281		40
41	4100	308139	553446	861585		861585		861585	41
44	4400	383024	650695	1033719		1033719		1033719	44
46.30	4650								46.30
49	4900	202575	22447	225022	-40515	184507	-2792	181715	49
50	5000	431795	18863	450658		450658		450658	50
53	5300	21937	5858	27795	30386	58181	-21937	36244	53
54	5400		56796	56796	10129	66925	-56700	10225	54
55	5500		336869	336869		336869	-831	336038	55
56	5600		363820	363820		363820		363820	56
59	5950		450267	450267		450267		450267	59
OUTPATIENT SERVICE COST CENTERS									
61	6100	347989	1231049	1579038	-44046	1534992	-660177	874815	61
62	6200								62
63.50	6310	1216817	443390	1660207	57923	1718130	-62070	1656060	63.50
63.60	6320								63.60
OTHER REIMBURSABLE COST CENTERS									
65	6500	342335	48874	391209		391209		391209	65
69.10	6910								69.10
69.20	6920								69.20
69.30	6930								69.30
69.40	6940								69.40
71	7100								71
SPECIAL PURPOSE COST CENTERS									
85.01	8510								85.01
85.02	8520								85.02
85.03	8530								85.03
95		6260544	11041214	17301758		17301758	-1683812	15617946	95
NONREIMBURSABLE COST CENTERS									
96	9600								96
98	9800	24936	9806	34742		34742		34742	98
101	TOTAL	6285480	11051020	17336500		17336500	-1683812	15652688	101

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----				
		COST CENTER	LINE #	SALARY	OTHER	
1		2	3	4	5	
1 DEPRICIATION	A	NEW CAP RHC REL COSTS-BLDG &	3.01		166211	1
2 RESPIRATORY THERAPY	B	ELECTROCARDIOLOGY	53	30386		2
3	B	ELECTROENCEPHALOGRAPHY	54	10129		3
4 INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	3.01		7393	4
5	C	NEW CAP REL COSTS-MVBLE EQUIP	4		5879	5
6 OPERATING ROOM	D	OPERATING ROOM	37		13606	6
7 RHC PHYSICIAN	E	RHC	63.50		57923	7
8	E					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
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				40515	251012	36

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 1

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- COST CENTER -----	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 DEPRICIATION	A	NEW CAP REL COSTS-BLDG & FIXT	3		166211	9 1
2 RESPIRATORY THERAPY	B	RESPIRATORY THERAPY	49	40515		2
3	B					3
4 INSURANCE EXPENSE	C	NEW CAP REL COSTS-BLDG & FIXT	3		13272	12 4
5	C					12 5
6 OPERATING ROOM	D	ANESTHESIOLOGY	40		13606	6
7 RHC PHYSICIAN	E	ADMINISTRATIVE & GENERAL	6		13877	7
8	E	EMERGENCY	61		44046	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
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				40515	251012	36

ANALYSIS OF CHANGES DURING COST REPORTING
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	132111					132111		1
2 LAND IMPROVEMENTS	226853	118999		118999		345852		2
3 BUILDINGS AND FIXTURES	11584839	327541		327541		11912380		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	5537216	577411		577411	72168	6042459		5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL	17481019	1023951		1023951	72168	18432802		7
8 RECONCILING ITEMS								8
9 TOTAL	17481019	1023951		1023951	72168	18432802		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	10376652		10376652	.567008				3
3.01 NEW CAP RHC REL COSTS-BLDG & PI	1881580		1881580	.102815				3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	6042459		6042459	.330177				4
5 TOTAL	18300691		18300691	1.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	488020		65476	26093			579589 3
3.01 NEW CAP RHC REL COSTS-BLDG & FIX	166211	16632		7393	3013		193249 3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	531044	190777		5879			727700 4
5 TOTAL	1185275	207409	65476	39365	3013		1500538 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	654231		341586	39365			1035182 3
3.01 NEW CAP RHC REL COSTS-BLDG & FIX		16632			3013		19645 3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	531044	190777					721821 4
5 TOTAL	1185275	207409	341586	39365	3013		1776648 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES	B	-276110	NEW CAP REL COSTS-BLDG & FIXT	3	11 3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER					5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES					7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS	B	-1800	ADMINISTRATIVE & GENERAL	6	8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-3538	ADMINISTRATIVE & GENERAL	6	9
10 TELEVISION AND RADIO SERVICE					10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST				
	A-8-2	-769054			12
13 SALE OF SCRAP, WASTE, ETC.	B	-980	ADMINISTRATIVE & GENERAL	6	13
14 RELATED ORGANIZATION TRANSACTIONS	WKST				
	A-8-1				14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-92294	DIETARY	11	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-831	MEDICAL SUPPLIES CHARGED TO PAT	55	18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4429	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4				35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST WKST A-8-4				36
37 EKG PHYSICIAN EMPLOYEE BENEFITS	A	-11128	EMPLOYEE BENEFITS	5	37
38 MISCELLANEOUS REVENUE	B	-19384	ADMINISTRATIVE & GENERAL	6	38
39 PUBLIC RELATIONS	A	-82119	ADMINISTRATIVE & GENERAL	6	39
40 LOBBYING EXPENSE	A	-7840	ADMINISTRATIVE & GENERAL	6	40
41 CRNA EXPENSE	A	-248281	ANESTHESIOLOGY	40	41
42 EMPLOYEE BENEFITS LAB TESTS	A	-3118	EMPLOYEE BENEFITS	5	42
43					43
44 PHYSICIAN CLINIC EXPENSE	A	-34622	RHC	63.50	44
45 PHYSICIAN RECRUITMENT	A	-128284	EMPLOYEE BENEFITS	5	45
46					46
47					47
48					48
49					49
50 TOTAL		-1683812			50

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 THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJ- USTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS					5

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
5						5

- (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:

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2008 TO 02/28/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2009.01
 07/02/2009 09:11

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1	2			3	4	5	6	7	8	9
1	44	LABORATORY		28137		28137				
2	63.50	RHC	AGGREGATE	27448	27448					
3	53	ELECTROCARDIOLOGY	AGGREGATE	21937	21937					
4	61	EMERGENCY	AGGREGATE	1142175	660177	481998				
5	54	ELECTROENCEPHALOGRAPHY	AGGREGATE	56700	56700					
6	49	RESPIRATORY THERAPY	AGGREGATE	2792	2792					
101		TOTAL		1279189	769054	510135				

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION 0	NEW CAP BLDGS & FIXTURES 3	NEW RHC BUILDING FIXTURES 3.01	NEW CAP MOVABLE EQUIPMENT 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINIS-TRATIVE & GENERAL 6	OPERATION OF PLANT 8	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	579589	579589							3
3.01 NEW CAP RHC REL COSTS-BLDG & FI	193249		193249						3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	727700			727700					4
5 EMPLOYEE BENEFITS	2831938			748	2832686				5
6 ADMINISTRATIVE & GENERAL	1556854	250865		52390	284234	2144343	2144343		6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	486873	4305		12804	62207	566189	89878	656067	8
8.01 RHC UTILITY EXPENSE	26931					26931	4275		8.01
9 LAUNDRY & LINEN SERVICE	70992			231		71223	11306		9
10 HOUSEKEEPING	214884	2362		1289	80412	298947	47455	4923	10
11 DIETARY	196760	10037		13767	71728	292292	46399	20924	11
12 CAFETERIA		3220				3220	511	6714	12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	189230	4809		1907	80550	276496	43892	10026	14
15 CENTRAL SERVICES & SUPPLY	22069	4680		2201	9544	38494	6111	9757	15
16 PHARMACY	154507	2608		2053	69831	228999	36352	5438	16
17 MEDICAL RECORDS & LIBRARY	272209	35327		15400	108253	431189	68448	73650	17
18 SOCIAL SERVICE									18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	926842	67982		41266	413844	1449934	230165	141729	25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	520964	43657		112517	174762	851900	135232	91016	37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC	861585	32247		259065	142580	1295477	205647	67227	41
44 LABORATORY	1033719	10251		64269	177230	1285469	204058	21372	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	181715	3607		9063	73695	268080	42556	7519	49
50 PHYSICAL THERAPY	450658		50405	15678	199797	716538	113745		50
53 ELECTROCARDIOLOGY	36244	3607		6049	14060	59960	9518	7519	53
54 ELBCTROENCEPHALOGRAPHY	10225	3596		2687	4687	21195	3365	7497	54
55 MEDICAL SUPPLIES CHARGED TO PAT	336038					336038	53343		55
56 DRUGS CHARGED TO PATIENTS	363820					363820	57754		56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	450267	27717		243		478227	75915	57783	59
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY	874815	29209		11640	161019	1076683	170915	60894	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC	1656060		142844	57746	534312	2390962	379546		63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
65 AMBULANCE SERVICES	391209	12720		43297	158403	605629	96139	26519	65
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	15617946	552806	193249	726310	2821148	15578235	2132525	620507	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		2888				2888	458	6020	96
98 PHYSICIANS' PRIVATE OFFICES	34742	23895		1390	11538	71565	11360	29540	98
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	15652688	579589	193249	727700	2832686	15652688	2144343	656067	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		RHC UTILITY EXPENSE 8.01	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS- TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	
GENERAL SERVICE COST CENTERS										
1	OLD CAP REL COSTS-BLDG & FIXT									1
2	OLD CAP REL COSTS-MVBLE EQUIP									2
3	NEW CAP REL COSTS-BLDG & FIXT									3
3.01	NEW CAP RHC REL COSTS-BLDG & FI									3.01
4	NEW CAP REL COSTS MVBLE EQUIP									4
5	EMPLOYEE BENEFITS									5
6	ADMINISTRATIVE & GENERAL									6
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT									8
8.01	RHC UTILITY EXPENSE	31206								8.01
9	LAUNDRY & LINEN SERVICE		82529							9
10	HOUSEKEEPING			351325						10
11	DIETARY		1121	7959	368695					11
12	CAFETERIA			2564	253609	266618				12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION					6895	337309			14
15	CENTRAL SERVICES & SUPPLY		1595	3711		2298	4215	66181		15
16	PHARMACY			2066		4597	9451	227	287130	16
17	MEDICAL RECORDS & LIBRARY			9221		18387				17
18	SOCIAL SERVICE									18
20	NONPHYSICIAN ANESTHETISTS									20
21	NURSING SCHOOL									21
22	I&R SERVICES-SALARY & FRINGES A									22
23	I&R SERVICES-OTHER PRGM COSTS A									23
24	PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS										
25	ADULTS & PEDIATRICS		40200	57738	115086	57463	115469	1162		25
ANCILLIARY SERVICE COST CENTERS										
37	OPERATING ROOM		10651	34627		16089	31760	21852		37
40	ANESTHESIOLOGY									40
41	RADIOLOGY DIAGNOSTIC		7858	25578		16089	32202	3287		41
44	LABORATORY			8131		20686	41778	26847		44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY			2870		16089	21827	536		49
50	PHYSICAL THERAPY	4211	4094	33269		18387		837		50
53	ELECTROCARDIOLOGY		1018	2870				20		53
54	ELECTROENCEPHALOGRAPHY			2851						54
55	MEDICAL SUPPLIES CHARGED TO PAT							7448		55
56	DRUGS CHARGED TO PATIENTS								287130	56
59	PSYCHIATRIC/PSYCHOLOGICAL SERVI			21963						59
OUTPATIENT SERVICE COST CENTERS										
61	EMERGENCY		10868	23168		18387	35744	1851		61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	RHC	24717	2073	81402		45969		1822		63.50
63.60	FQHC									63.60
OTHER REIMBURSABLE COST CENTERS										
65	AMBULANCE SERVICES		3051	10082		22984	44863	292		65
69.10	CMHC									69.10
69.20	OUTPATIENT PHYSICAL THERAPY									69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40	OUTPATIENT SPEECH PATHOLOGY									69.40
71	HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS										
85.01	PANCREAS ACQUISITION									85.01
85.02	INTESTINAL ACQUISITION									85.02
85.03	ISLET CELL ACQUISITION									85.03
95	SUBTOTALS	28928	82529	330070	368695	264320	337309	66181	287130	95
NONREIMBURSABLE COST CENTERS										
96	GIFT, FLOWER, COFFEE SHOP & CAN			2296						96
98	PHYSICIANS' PRIVATE OFFICES	2278		18959		2298				98
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL	31206	82529	351325	368695	266618	337309	66181	287130	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	17	25	26	27
GENERAL SERVICE COST CENTERS				
1				1
2				2
3				3
3.01				3.01
4				4
5				5
6				6
7				7
8				8
8.01				8.01
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17	600895			17
18				18
20				20
21				21
22				22
23				23
24				24
INPATIENT ROUTINE SERV COST CENTERS				
25				25
25	123261	2332207		2332207
ANCILLARY SERVICE COST CENTERS				
37	27873	1221000		1221000
40				40
41	267812	1921177		1921177
44		1608341		1608341
46.30				46.30
49		359477		359477
50		891081		891081
53		80905		80905
54		34908		34908
55		396829		396829
56		708704		708704
59		633888		633888
OUTPATIENT SERVICE COST CENTERS				
61	136423	1534933		1534933
62				62
63.50		2926491		2926491
63.60				63.60
63.60				63.60
OTHER REIMBURSABLE COST CENTERS				
65		809559		809559
69.10				69.10
69.20				69.20
69.30				69.30
69.40				69.40
71				71
SPECIAL PURPOSE COST CENTERS				
85.01				85.01
85.02				85.02
85.03				85.03
95	555369	15459500		15459500
NONREIMBURSABLE COST CENTERS				
96		11662		11662
98	45526	181526		181526
101				101
102				102
103	600895	15652688		15652688

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW RHC BUILDING FIXTURES 3.01	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	EMPLOYEE BENEFITS 5	ADMINIS- TRATIVE & GENERAL 6	OPERATION OF PLANT 8	
GENERAL SERVICE COST CENTERS									
1									1
2									2
3									3
3.01									3.01
4									4
5				748	748	748			5
6		250865		52390	303255	75	303330		6
7									7
8		4305		12804	17109	16	12714	29839	8
8.01							605		8.01
9				231	231		1599		9
10		2362		1289	3651	21	6713	224	10
11		10037		13767	23804	19	6563	952	11
12		3220			3220		72	305	12
13									13
14		4809		1907	6716	21	6209	456	14
15		4680		2201	6881	3	864	444	15
16		2608		2053	4661	18	5142	247	16
17		35327		15400	50727	29	9682	3350	17
18									18
20									20
21									21
22									22
23									23
24									24
INPATIENT ROUTINE SERV COST CENTERS									
25		67982		41266	109248	109	32558	6444	25
ANCILLARY SERVICE COST CENTERS									
37		43657		112517	156174	46	19129	4140	37
40									40
41		32247		259065	291312	38	29090	3058	41
44		10251		64269	74520	47	28865	972	44
46.30									46.30
49		3607		9063	12670	19	6020	342	49
50			50405	15678	66083	53	16090		50
53		3607		6049	9656	4	1346	342	53
54		3596		2687	6283	1	476	341	54
55							7546		55
56							8170		56
59		27717		243	27960		10739	2628	59
OUTPATIENT SERVICE COST CENTERS									
61		29209		11640	40849	42	24177	2770	61
62									62
63.50			142844	57746	200590	142	53690		63.50
63.60									63.60
OTHER REIMBURSABLE COST CENTERS									
65		12720		43297	56017	42	13599	1206	65
69.10									69.10
69.20									69.20
69.30									69.30
69.40									69.40
71									71
SPECIAL PURPOSE COST CENTERS									
85.01									85.01
85.02									85.02
85.03									85.03
95		552806	193249	726310	1472365	745	301658	28221	95
NONREIMBURSABLE COST CENTERS									
96		2888			2888		65	274	96
98		23895		1390	25285	3	1607	1344	98
101									101
102									102
103		579589	193249	727700	1500538	748	303330	29839	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	RHC UTILITY EXPENSE 8.01	LAUNDRY & LINEN SERVICE 9	HOUSE- KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINIS- TRATION 14	CENTRAL SERVICES & SUPPLY 15	PHARMACY 16	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT									3
3.01 NEW CAP RHC REL COSTS-BLDG & FI									3.01
4 NEW CAP REL COSTS-MVBLE EQUIP									4
5 EMPLOYEE BENEFITS									5
6 ADMINISTRATIVE & GENERAL									6
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT									8
8.01 RHC UTILITY EXPENSE	605								8.01
9 LAUNDRY & LINEN SERVICE		1830							9
10 HOUSEKEEPING			10609						10
11 DIETARY		25	240	31603					11
12 CAFETERIA			77	21738	25412				12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION					657	14059			14
15 CENTRAL SERVICES & SUPPLY		35	112		219	176	8734		15
16 PHARMACY			62		438	394	30	10992	16
17 MEDICAL RECORDS & LIBRARY			278		1753				17
18 SOCIAL SERVICE									18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & PRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS		891	1744	9865	5477	4812	153		25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		236	1046		1533	1324	2884		37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC		174	772		1533	1342	434		41
44 LABORATORY			246		1972	1741	3543		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY			87		1533	910	71		49
50 PHYSICAL THERAPY	82	91	1005		1753		110		50
53 ELECTROCARDIOLOGY		23	87				3		53
54 ELECTROENCEPHALOGRAPHY			86						54
55 MEDICAL SUPPLIES CHARGED TO PAT							983		55
56 DRUGS CHARGED TO PATIENTS								10992	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI			663						59
OUTPATIENT SERVICE COST CENTERS									
61 EMERGENCY		241	700		1753	1490	244		61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC	479	46	2458		4381		240		63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
65 AMBULANCE SERVICES		68	304		2191	1870	39		65
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	561	1830	9967	31603	25193	14059	8734	10992	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN			69						96
98 PHYSICIANS' PRIVATE OFFICES	44		573		219				98
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	605	1830	10609	31603	25412	14059	8734	10992	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	17	25	26	27
GENERAL SERVICE COST CENTERS				
1 OLD CAP REL COSTS-BLDG & FIXT				1
2 OLD CAP REL COSTS-MVBLE EQUIP				2
3 NEW CAP REL COSTS-BLDG & FIXT				3
3.01 NEW CAP RHC REL COSTS-BLDG & FI				3.01
4 NEW CAP REL COSTS-MVBLE EQUIP				4
5 EMPLOYEE BENEFITS				5
6 ADMINISTRATIVE & GENERAL				6
7 MAINTENANCE & REPAIRS				7
8 OPERATION OF PLANT				8
8.01 RHC UTILITY EXPENSE				8.01
9 LAUNDRY & LINEN SERVICE				9
10 HOUSEKEEPING				10
11 DIETARY				11
12 CAFETERIA				12
13 MAINTENANCE OF PERSONNEL				13
14 NURSING ADMINISTRATION				14
15 CENTRAL SERVICES & SUPPLY				15
16 PHARMACY				16
17 MEDICAL RECORDS & LIBRARY	65819			17
18 SOCIAL SERVICE				18
20 NONPHYSICIAN ANESTHETISTS				20
21 NURSING SCHOOL				21
22 I&R SERVICES-SALARY & FRINGES A				22
23 I&R SERVICES-OTHER PRGM COSTS A				23
24 PARAMED ED PRGM-(SPECIFY)				24
INPATIENT ROUTINE SERV COST CENTERS				
25 ADULTS & PEDIATRICS	13501	184802		184802
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	3053	189565		189565
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	29335	357088		357088
44 LABORATORY		111906		111906
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY		21652		21652
50 PHYSICAL THERAPY		85267		85267
53 ELECTROCARDIOLOGY		11461		11461
54 ELECTROENCEPHALOGRAPHY		7187		7187
55 MEDICAL SUPPLIES CHARGED TO PAT		8529		8529
56 DRUGS CHARGED TO PATIENTS		19162		19162
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI		41990		41990
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	14943	87209		87209
62 OBSERVATION BEDS (NON-DISTINCT				62
63.50 RHC		262026		262026
63.60 FQHC				63.60
OTHER REIMBURSABLE COST CENTERS				
65 AMBULANCE SERVICES		75336		75336
69.10 CMHC				69.10
69.20 OUTPATIENT PHYSICAL THERAPY				69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY				69.30
69.40 OUTPATIENT SPEECH PATHOLOGY				69.40
71 HOME HEALTH AGENCY				71
SPECIAL PURPOSE COST CENTERS				
85.01 PANCREAS ACQUISITION				85.01
85.02 INTESTINAL ACQUISITION				85.02
85.03 ISLET CELL ACQUISITION				85.03
95 SUBTOTALS	60832	1463180		1463180
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & CAN		3296		3296
98 PHYSICIANS' PRIVATE OFFICES	4987	34062		34062
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 TOTAL	65819	1500538		1500538

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	RHC UTILITY EXPENSE SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.
	8.01	9	10	11	12	14	15	16
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
3.01 NEW CAP RHC REL COSTS-BLDG &								3.01
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
8.01 RHC UTILITY EXPENSE	12413							8.01
9 LAUNDRY & LINEN SERVICE		22455						9
10 HOUSEKEEPING			18364					10
11 DIETARY		305	416	55157				11
12 CAFETERIA			134	37940	116			12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION						3	153395	14
15 CENTRAL SERVICES & SUPPLY		434	194			1	1917	15
16 PHARMACY			108			2	4298	16
17 MEDICAL RECORDS & LIBRARY			482			8	2648	17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES								22
23 I&R SERVICES-OTHER PRGM COSTS								23
24 PARAMED ED PRGM-(SPECIFY)								24
25 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS		10938	3018	17217		25	52511	13565
37 ANCILLARY SERVICE COST CENTERS								
OPERATING ROOM		2898	1810			7	14443	255150
40 ANESTHESIOLOGY								37
41 RADIOLOGY-DIAGNOSTIC		2138	1337			7	14644	38378
44 LABORATORY			425			9	18999	313476
46.30 BLOOD CLOTTING FACTORS ADMIN								44
49 RESPIRATORY THERAPY			150			7	9926	6258
50 PHYSICAL THERAPY	1675	1114	1739			8	9774	232
53 ELECTROCARDIOLOGY		277	150					50
54 ELECTROENCEPHALOGRAPHY			149					53
55 MEDICAL SUPPLIES CHARGED TO P							86964	54
56 DRUGS CHARGED TO PATIENTS								55
59 PSYCHIATRIC/PSYCHOLOGICAL SER			1148					56
61 EMERGENCY		2957	1211			8	16255	21614
62 OBSERVATION BEDS (NON-DISTINC								59
63.50 RHC	9832	564	4255			20	21269	61
63.60 FQHC								62
65 OTHER REIMBURSABLE COST CENTERS		830	527			10	20402	3415
69.10 CMHC								63.50
69.20 OUTPATIENT PHYSICAL THERAPY								63.60
69.30 OUTPATIENT OCCUPATIONAL THERA								65
69.40 OUTPATIENT SPEECH PATHOLOGY								69.10
71 HOME HEALTH AGENCY								69.20
85.01 PANCREAS ACQUISITION								69.30
85.02 INTESTINAL ACQUISITION								69.40
85.03 ISLET CELL ACQUISITION								71
95 SUBTOTALS	11507	22455	17253	55157	115	153395	772743	319098
96 NONREIMBURSABLE COST CENTERS								95
GIFT, FLOWER, COFFEE SHOP & C			120					96
98 PHYSICIANS' PRIVATE OFFICES	906		991			1		98
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	31206	82529	351325	368695	266618	337309	66181	287130
104 UNIT COST MULT-WS B PT I	2.513977		19.131181		2298.431034		.085644	103
104 UNIT COST MULT-WS B PT I		3.675306		6.684464		2.198957		104
105 COST TO BE ALLOC PER B PT II								104
106 UNIT COST MULT-WS B PT II								105
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III	605	1830	10609	31603	25412	14059	8734	10992
108 UNIT COST MULT-WS B PT III	.048739		.577706		219.068966		.011303	107
108 UNIT COST MULT-WS B PT III		.081496		.572964		.091652		108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT	
	17	
GENERAL SERVICE COST CENTERS		
1 OLD CAP REL COSTS-BLDG & FIXT		1
2 OLD CAP REL COSTS-MVBLE EQUIP		2
3 NEW CAP REL COSTS-BLDG & FIXT		3
3.01 NEW CAP RHC REL COSTS-BLDG &		3.01
4 NEW CAP REL COSTS-MVBLE EQUIP		4
5 EMPLOYEE BENEFITS		5
6 ADMINISTRATIVE & GENERAL		6
7 MAINTENANCE & REPAIRS		7
8 OPERATION OF PLANT		8
8.01 RHC UTILITY EXPENSE		8.01
9 LAUNDRY & LINEN SERVICE		9
10 HOUSEKEEPING		10
11 DIETARY		11
12 CAFETERIA		12
13 MAINTENANCE OF PERSONNEL		13
14 NURSING ADMINISTRATION		14
15 CENTRAL SERVICES & SUPPLY		15
16 PHARMACY		16
17 MEDICAL RECORDS & LIBRARY	7761	17
18 SOCIAL SERVICE		18
20 NONPHYSICIAN ANESTHETISTS		20
21 NURSING SCHOOL		21
22 I&R SERVICES-SALARY & FRINGES		22
23 I&R SERVICES-OTHER PRGM COSTS		23
24 PARAMED ED PRGM-(SPECIFY)		24
25 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS	1592	25
ANCILLARY SERVICE COST CENTERS		
37 OPERATING ROOM	360	37
40 ANESTHESIOLOGY		40
41 RADIOLOGY-DIAGNOSTIC	3459	41
44 LABORATORY		44
46.30 BLOOD CLOTTING FACTORS ADMIN		46.30
49 RESPIRATORY THERAPY		49
50 PHYSICAL THERAPY		50
53 ELECTROCARDIOLOGY		53
54 ELECTROENCEPHALOGRAPHY		54
55 MEDICAL SUPPLIES CHARGED TO P		55
56 DRUGS CHARGED TO PATIENTS		56
59 PSYCHIATRIC/PSYCHOLOGICAL SER		59
61 OUTPATIENT SERVICE COST CENTERS EMERGENCY	1762	61
62 OBSERVATION BEDS (NON-DISTINC		62
63.50 RHC		63.50
63.60 PQHC		63.60
OTHER REIMBURSABLE COST CENTERS		
65 AMBULANCE SERVICES		65
69.10 CMHC		69.10
69.20 OUTPATIENT PHYSICAL THERAPY		69.20
69.30 OUTPATIENT OCCUPATIONAL THERA		69.30
69.40 OUTPATIENT SPEECH PATHOLOGY		69.40
71 HOME HEALTH AGENCY		71
SPECIAL PURPOSE COST CENTERS		
85.01 PANCREAS ACQUISITION		85.01
85.02 INTESTINAL ACQUISITION		85.02
85.03 ISLET CELL ACQUISITION		85.03
95 SUBTOTALS	7173	95
NONREIMBURSABLE COST CENTERS		
96 GIFT, FLOWER, COFFEE SHOP & C		96
98 PHYSICIANS' PRIVATE OFFICES	588	98
101 CROSS FOOT ADJUSTMENTS		101
102 NEGATIVE COST CENTER		102
103 COST TO BE ALLOC PER B PT I	600895	103
104 UNIT COST MULT-WS B PT I	77.424945	104
104 UNIT COST MULT-WS B PT I		104
105 COST TO BE ALLOC PER B PT II		105
106 UNIT COST MULT-WS B PT II		106
106 UNIT COST MULT-WS B PT II		106
107 COST TO BE ALLOC PER B PT III	65819	107
108 UNIT COST MULT-WS B PT III	8.480737	108
108 UNIT COST MULT-WS B PT III		108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	2332207					25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	1221000					37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	1921177					41
44 LABORATORY	1608341					44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	359477					49
50 PHYSICAL THERAPY	891081					50
53 ELECTROCARDIOLOGY	80905					53
54 ELECTROENCEPHALOGRAPHY	34908					54
55 MEDICAL SUPPLIES CHARGED TO	396829					55
56 DRUGS CHARGED TO PATIENTS	708704					56
59 PSYCHIATRIC/PSYCHOLOGICAL S	633888					59
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	1534933					61
62 OBSERVATION BEDS (NON-DISTI	111786		111786		111786	62
63.50 RHC	2926491					63.50
63.60 PQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES	809559					65
101 SUBTOTAL	15571286		111786		111786	101
102 LESS OBSERVATION BEDS	111786		111786		111786	102
103 TOTAL	15459500					103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	CHARGES			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25 INPATIENT ROUTINE SERV COST CENTERS						25
ADULTS & PEDIATRICS	2205512		2205512			
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	397814	1923588	2321402	.525975		37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	864218	5606946	6471164	.296883		41
44 LABORATORY	945490	4657154	5602644	.287068		44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	311100	145290	456390	.787653		49
50 PHYSICAL THERAPY	202501	1694756	1897257	.469668		50
53 ELECTROCARDIOLOGY	47608	380013	427621	.189198		53
54 ELECTROENCEPHALOGRAPHY	3314	293830	297144	.117478		54
55 MEDICAL SUPPLIES CHARGED TO	1240170	1342414	2582584	.153656		55
56 DRUGS CHARGED TO PATIENTS	2203532	1163543	3367075	.210481		56
59 PSYCHIATRIC/PSYCHOLOGICAL S		1050355	1050355	.603499		59
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	72660	1983713	2056373	.746427		61
62 OBSERVATION BEDS (NON-DISTI	3413	176757	180170	.620447	.620447	.620447 62
63.50 RHC		1474353	1474353	1.984932		63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES		686599	686599	1.179086		65
101 SUBTOTAL	8497332	22579311	31076643			101
102 LESS OBSERVATION BEDS						102
103 TOTAL			31076643			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1351) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES		
	PART II COL. 8	PART I COL. 9	PART II COL. 9	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC
	1	1.01	1.02	2	3	4
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	.525975	.525975	.525975			37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	.296883	.296883	.296883			41
44 LABORATORY	.287068	.287068	.287068			44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	.787653	.787653	.787653			49
50 PHYSICAL THERAPY	.469668	.469668	.469668			50
53 ELECTROCARDIOLOGY	.189198	.189198	.189198			53
54 ELECTROENCEPHALOGRAPHY	.117478	.117478	.117478			54
55 MEDICAL SUPPLIES CHARGED TO PAT	.153656	.153656	.153656			55
56 DRUGS CHARGED TO PATIENTS	.210481	.210481	.210481			56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.603499	.603499	.603499			59
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY	.746427	.746427	.746427			61
62 OBSERVATION BEDS (NON-DISTINCT	.620447	.620447	.620447			62
63.50 RHC	1.984932	1.984932	1.984932			63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES	1.179086	1.179086	1.179086			65
65.01 AMBULANCE CHARGES (S-2 LINE 56.	1.179086	1.179086				65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.	1.179086	1.179086				65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.	1.179086	1.179086				65.03
101 SUBTOTAL						101
102 CRNA CHARGES						102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS						103
104 NET CHARGES						104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	1	.210481	1
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)	2		2
2.01 VACCINE CHARGES - HEPATITIS B	2.01		2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)	3		3
3.01 VACCINE COSTS - HEPATITIS B	3.01		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK	[]	TITLE V - O/P	[XX]	HOSPITAL (14-1351)	[]	SNF
APPLICABLE	[XX]	TITLE XVIII-PT B	[]	SUB I	[]	NF
BOXES	[]	TITLE XIX - O/P	[]	SUB II	[]	S/B-SNF
			[]	SUB III	[]	S/B-NF
			[]	SUB IV	[]	ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1)	PPS SER- VICES	ALL OTHER	PPS SER- VICES	PPS SER- VICES	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OTHER OUTPATIENT DIAGNOSTIC
	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	(SEE INSTRU.)	6	7	8
	5	5.01	5.02	5.03	5.04			
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		835256						37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC		2321368						41
44 LABORATORY		2063119						44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY		145271						49
50 PHYSICAL THERAPY		579308						50
53 ELECTROCARDIOLOGY		166180						53
54 ELECTROENCEPHALOGRAPHY		98131						54
55 MEDICAL SUPPLIES CHARGED TO PA		426975						55
56 DRUGS CHARGED TO PATIENTS		492351						56
59 PSYCHIATRIC/PSYCHOLOGICAL SERV		996031						59
OUTPATIENT SERVICE COST CENTERS								
61 EMERGENCY		714885						61
62 OBSERVATION BEDS (NON-DISTINCT		50476						62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65 AMBULANCE SERVICES								65
65.01 AMBULANCE CHARGES (S-2 LINE 56								65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56								65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56								65.03
101 SUBTOTAL		8889351						101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES		8889351						104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D
 PARTS V & VI

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1351) [] SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] SUB I [] NF
 BOXES [] TITLE XIX - O/P [] SUB II [] S/B-SNF
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST					HOSPITAL	HOSPITAL
	ALL OTHER (COLS 1x5)	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03)	PPS SERVICES (COLUMNS 1.01x5.04)	I/P PART B CHARGES (SEE INSTRU.)	I/P PART B COST (COLUMNS 1.02x10)
	9	9.01	9.02	9.03	9.04	10	11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	439324						37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	689175						41
44 LABORATORY	592255						44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	114423						49
50 PHYSICAL THERAPY	272082						50
53 ELECTROCARDIOLOGY	31441						53
54 ELECTROENCEPHALOGRAPHY	11528						54
55 MEDICAL SUPPLIES CHARGED TO PAT	65607						55
56 DRUGS CHARGED TO PATIENTS	103631						56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	601104						59
OUTPATIENT SERVICE COST CENTERS							
61 EMERGENCY	533609						61
62 OBSERVATION BEDS (NON-DISTINCT	31318						62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES							65
65.01 AMBULANCE CHARGES (S-2 LINE 56.							65.01
65.02 AMBULANCE CHARGES (S-2 LINE 56.							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL	3485497						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	3485497						104

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	4882						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	4323						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4323						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	466						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	93						6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	3046						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	419						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	84						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							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	100.00						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	100.00						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2332207						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	267045						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2065162						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2205512						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2205512						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.936364						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	510.18						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2065162						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	477.72					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1455135					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1455135					41
	TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 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
	HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	1156399					48
49 TOTAL PROGRAM INPATIENT COSTS	2611534					49
PASS THROUGH COST ADJUSTMENTS						
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II (CONT)

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
54						PROGRAM DISCHARGES
55						TARGET AMOUNT PER DISCHARGE
56						TARGET AMOUNT
57						DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58						BONUS PAYMENT
58.01						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)
59.02						PROGRAM DISCHARGES PRIOR TO JULY 1
59.03						PROGRAM DISCHARGES AFTER JULY 1
59.04						PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05						REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60	200165					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61	40128					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
62	240293					TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65						TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

[] TITLE V-INPT [XX] TITLE XVIII-PART A [] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

SNF

	1	
66 SNF/NF/ICF/MR ROUTINE SERVICE COST		66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM		67
68 PROGRAM ROUTINE SERVICE COST		68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM		69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS		70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS		71
72 PER DIEM CAPITAL RELATED COSTS		72
73 PROGRAM CAPITAL RELATED COSTS		73
74 INPATIENT ROUTINE SERVICE COST		74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS		75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT		76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		77
78 INPATIENT ROUTINE SERVICE COST LIMITATION		78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS		79
80 PROGRAM INPATIENT ANCILLARY SERVICES		80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION		81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS		82

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
PERIOD FROM 03/01/2008 TO 02/28/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01
07/02/2009 09:11

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1351)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	234	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	477.72	84
85 OBSERVATION BED COST	111786	85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[] TITLE V [XX] HOSPITAL (14-1351) [] SNF [] PPS
 [XX] TITLE XVIII-PT A [] SUB I [] NF [] TEPRA
 [] TITLE XIX [] SUB II [] S/B-SNF [XX] OTHER
 [] SUB III [] S/B-NF
 [] SUB IV [] ICF/MR

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		1591523		25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.525975	292803	154007	37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.296883	517784	153721	41
44 LABORATORY	.287068	612863	175933	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.787653	217079	170983	49
50 PHYSICAL THERAPY	.469668	133734	62811	50
53 ELECTROCARDIOLOGY	.189198	40045	7576	53
54 ELECTROENCEPHALOGRAPHY	.117478	1704	200	54
55 MEDICAL SUPPLIES CHARGED TO PAT	.153656	859149	132013	55
56 DRUGS CHARGED TO PATIENTS	.210481	1417478	298352	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.603499			59
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.746427			61
62 OBSERVATION BEDS (NON-DISTINCT	.620447	1294	803	62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	1.984932			63.50
63.60 FQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		4093933	1156399	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		4093933		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEPRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input checked="" type="checkbox"/> S/B-SNF (14-Z351)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.525975			37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.296883	37419	11109	41
44 LABORATORY	.287068	47995	13778	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.787653	37562	29586	49
50 PHYSICAL THERAPY	.469668	58558	27503	50
53 ELECTROCARDIOLOGY	.189198	1567	296	53
54 ELECTROENCEPHALOGRAPHY	.117478	483	57	54
55 MEDICAL SUPPLIES CHARGED TO PAT	.153656	96367	14807	55
56 DRUGS CHARGED TO PATIENTS	.210481	175523	36944	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	.603499			59
OUTPATIENT SERVICE COST CENTERS				
61 EMERGENCY	.746427			61
62 OBSERVATION BEDS (NON-DISTINCT	.620447			62
OTHER REIMBURSABLE COST CENTERS				
63.50 RHC	1.984932			63.50
63.60 PQHC				63.60
65 AMBULANCE SERVICES				65
101 TOTAL		455474	134080	101
102 LESS PBP CLINIC LAB SVCS PGM ONLY CHARGES				102
103 NET CHARGES		455474		103

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A

PART A	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
DRG AMOUNT						
1						1
1.01						1.01
1.02						1.02
1.03						1.03
1.04						1.04
1.05						1.05
1.06						1.06
1.07						1.07
1.08						1.08
2						2
2.01						2.01
3						3
3.01						3.01
3.02						3.02
3.03						3.03
3.04						3.04
3.05						3.05
3.06						3.06
3.07						3.07
3.08						3.08
3.09						3.09
3.10						3.10
3.11						3.11
3.12						3.12
3.13						3.13
3.14						3.14
3.15						3.15
3.16						3.16
3.17						3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART A
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
3.18						3.18
3.19						3.19
3.20						3.20
3.21						3.21
3.22						3.22
3.23						3.23
3.24						3.24
4						4
4.01						4.01
4.02						4.02
4.03						4.03
4.04						4.04
5						5
5.01						5.01
5.02						5.02
5.03						5.03
5.04						5.04
5.05						5.05
5.06						5.06
6						6
7						7
7.01						7.01
8						8
9						9
10						10
11						11
11.01						11.01
11.02						11.02
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
21.01						21.01
21.02						21.02
22						22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET B
PART A
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23						23
24						24
25						25
26						26
27						27
28						28
28.01						28.01
29						29
30						30
50						50
51						51
52						52
53						53
54						54
55						55
56						56

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1351) 1	HOSPITAL (14-1351) 1.01	HOSPITAL (14-1351) 1.02	
1 MEDICAL AND OTHER SERVICES	3485497			1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST	3485497			5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				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				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES	3520352			17
17.01 TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1351) 1	HOSPITAL (14-1351) 1.01	HOSPITAL (14-1351) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	62491		18
18.01 COINSURANCE	1372707		18.01
19 SUBTOTAL	2085154		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	2085154		23
24 PRIMARY PAYER PAYMENTS	1132		24
25 SUBTOTAL	2084022		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	324369		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	324369		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	309487		27.02
28 SUBTOTAL	2408391		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	2408391		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	2235693		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	172698		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
PERIOD FROM 03/01/2008 TO 02/28/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01
07/02/2009 09:11

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

	HOSPITAL (14-1351) OCTOBER 1, 1997 PRIOR TO ON OR AFTER	
	1	1.01
1 STANDARD OVERHEAD AMOUNTS (ASC FEES)		1
2 DEDUCTIBLES		2
3 SUBTOTAL		3
4 80 PERCENT OF LINE 3		4
5 ASC PORTION OF BLEND		5
6 OUTPATIENT ASC COST		6
COMPUTATION OF LESSER OF COST OR CHARGES		
7 TOTAL CHARGES		7
CUSTOMARY CHARGES		
8 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		8
9 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)		9
10 RATIO OF LINE 8 TO LINE 9		10
11 TOTAL CUSTOMARY CHARGES		11
12 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		12
13 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		13
14 LESSER OF COST OR CHARGES		14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15 DEDUCTIBLES AND COINSURANCE		15
16 TOTAL		16
17 HOSPITAL SPECIFIC PORTION OF BLEND		17
18 ASC BLENDED AMOUNT		18
19 LESSER OF LINES 16 OR 18		19
20 PART B DEDUCTIBLES AND COINSURANCE		20
21 ASC PAYMENT AMOUNT		21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[] TITLE V [XX] TITLE XVIII [] TITLE XIX

HOSPITAL
(14-1351)
OCTOBER 1, 1997
PRIOR TO ON OR AFTER
1 1.01

1	PREVAILING CHARGES	1
2	52 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OUTPATIENT RADIOLOGY	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	RADIOLOGY PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

TITLE V TITLE XVIII TITLE XIX

HOSPITAL
 (14-1351)
 OCTOBER 1, 1997
 PRIOR TO ON OR AFTER
 1 1.01

1	PREVAILING CHARGES	1
2	42 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	DIAGNOSTIC PAYMENT AMOUNT	21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 HOSPITAL (14-1351)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1781338		1996962	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 A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
PROGRAM .01	02/27/2009	103945	11/08/2008	105364	3.01
TO .02	02/27/2009	71	02/27/2009	234	3.02
PROVIDER .03			02/27/2009	188192	3.03
TO .04					3.04
PROVIDER .05					3.05
TO .50	11/08/2008	74068	11/08/2008	55059	3.50
PROVIDER .51	11/08/2008	15971			3.51
TO .52					3.52
PROGRAM .53					3.53
PROGRAM .54					3.54
SUBTOTAL .99		13977		238731	3.99
4 TOTAL INTERIM PAYMENTS		1795315		2235693	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					
PROGRAM .01					5.01
TO .02					5.02
PROVIDER .03					5.03
TO .50					5.50
PROVIDER .51					5.51
TO .52					5.52
PROGRAM .52					5.52
SUBTOTAL .99					5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.					
PROGRAM TO .01					6.01
PROVIDER TO .02					6.02
PROGRAM					
7 TOTAL MEDICARE PROGRAM LIABILITY					7

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
 DATE (MO/DAY/YR): _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 SWING BED SKILLED NURSING FACILITY (14-Z351)

WORKSHEET E-1

DESCRIPTION	INPATIENT PART A		PART B	
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		300190		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 A ZERO.		NONE		NONE 2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	02/27/2009	47311		3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54
PROGRAM .01				
TO .02				
PROVIDER .03			NONE	
TO .04				
PROVIDER .05				
TO .50				
PROVIDER .51				
TO .52		NONE		
PROGRAM .53			NONE	
.54				
SUBTOTAL	.99	47311		3.99
4 TOTAL INTERIM PAYMENTS		347501		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				5.01 5.02 5.03 5.50 5.51 5.52
PROGRAM .01				
TO .02				
PROVIDER .03				
TO .50				
PROVIDER .51				
TO .52				
PROGRAM .52				
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.				6.01 6.02
PROGRAM TO .01				
PROVIDER TO .02				
PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY				7

NAME OF INTERMEDIARY: _____
 SIGNATURE OF AUTHORIZED PERSON: _____

INTERMEDIARY NUMBER: _____
 DATE (MO/DAY/YR): _____

CALCULATION OF REIMBURSEMENT SETTLEMENT
 SWING BEDS

SUPPLEMENTAL
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V	--- TITLE XVIII ---		--- TITLE XIX ---		
	S/B NF	S/B SNF	S/B SNF	S/B SNF	S/B NF	
		PART A	PART B			
		(14-Z351)	(14-Z351)			
	1	1	2	1	1	
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF	242696				1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES	135421				3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS	503				5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL	378117				8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL	378117				10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL	378117				12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	16319				13
14	80% OF PART B COSTS					14
15	SUBTOTAL	361798				15
16	OTHER ADJUSTMENTS					16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)					17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					17.01
18	TOTAL	361798				18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS	347501				20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM	14297				21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF I
1	INPATIENT SERVICES	2611534				1
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)					1.01
2	ORGAN ACQUISITION					2
3	COST OF TEACHING PHYSICIANS					3
4	SUBTOTAL	2611534				4
5	PRIMARY PAYER PAYMENTS					5
6	TOTAL COST	2637649				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	TEACHING PHYSICIANS					10
11	TOTAL REASONABLE CHARGES					11
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS					12
13	AMOUNT 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)					13
14	RATIO OF LINE 12 TO LINE 13					14
15	TOTAL CUSTOMARY CHARGES					15
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST					16
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES					17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1351)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18						18
19						19
19	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS					
20	2637649					20
20	COST OF COVERED SERVICES					
21	423267					21
21	DEDUCTIBLES					
22	2214382					22
22	EXCESS REASONABLE COST					
23	34310					23
23	SUBTOTAL					
24	2180072					24
24	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
25	40231					25
25.01	40231					25.01
25.01	REDUCED REIMBURSABLE BAD DEBTS					
25.02						25.02
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)					
26	2220303					26
26	SUBTOTAL					
27						27
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					
28						28
28	OTHER ADJUSTMENTS					
29						29
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					
30	2220303					30
30	SUBTOTAL					
31						31
31	SEQUESTRATION ADJUSTMENT					
32	1795315					32
32	INTERIM PAYMENTS					
32.01						32.01
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					
33	424988					33
33	BALANCE DUE PROVIDER/PROGRAM					
34						34
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	962225			1
2	TEMPORARY INVESTMENTS	6324604			2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	2227801			4
5	OTHER RECEIVABLES	1565886			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	203034			7
8	PREPAID EXPENSES	155375			8
9	OTHER CURRENT ASSETS	58745			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	11497670			11
FIXED ASSETS					
12	LAND	132111			12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	345852			13
13.01	ACCUMULATED DEPRECIATION	-197472			13.01
14	BUILDINGS	11910819			14
14.01	ACCUMULATED DEPRECIATION	-5106153			14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT	6042459			16
16.01	ACCUMULATED DEPRECIATION	-4198548			16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT				18
18.01	ACCUMULATED DEPRECIATION				18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	8929068			21
OTHER ASSETS					
22	INVESTMENTS				22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	2699395			25
26	TOTAL OTHER ASSETS	2699395			26
27	TOTAL ASSETS	23126133			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	736863			28
29	SALARIES, WAGES & FEES PAYABLE	536293			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)				31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES	429757			35
36	TOTAL CURRENT LIABILITIES	1702913			36
LONG TERM LIABILITIES					
37	MORTGAGE PAYABLE				37
38	NOTES PAYABLE	6046688			38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES				41
42	TOTAL LONG TERM LIABILITIES	6046688			42
43	TOTAL LIABILITIES	7749601			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	15376532			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	15376532			51
52	TOTAL LIABILITIES AND FUND BALANCES	23126133			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	15950067			1
2 NET INCOME (LOSS)	-573535			2
3 TOTAL	15376532			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	15376532			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	15376532			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	2314611		2314611	1
2 SUBPROVIDER I				2
4 SWING BED - SNF				4
5 SWING BED - NF				5
6 SKILLED NURSING FACILITY				6
7 NURSING FACILITY				7
8 OTHER LONG TERM CARE				8
9 TOTAL GENERAL INPATIENT CARE SERVICES	2314611		2314611	9
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10 INTENSIVE CARE UNIT				10
11 CORONARY CARE UNIT				11
12 BURN INTENSIVE CARE UNIT				12
13 SURGICAL INTENSIVE CARE UNIT				13
14 OTHER SPECIAL CARE (SPECIFY)				14
15 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	2314611		2314611	15
16 TOTAL INPATIENT ROUTINE CARE SERVICES	6494139		6494139	16
17 ANCILLARY SERVICES				17
18 OUTPATIENT SERVICES		22369579	22369579	18
18.50 RHC		1801237	1801237	18.50
18.60 PQHC				18.60
19 HOME HEALTH AGENCY				19
20 AMBULANCE		689790	689790	20
21 CORP				21
22 ASC				22
23 HOSPICE				23
24				24
25 TOTAL PATIENT REVENUES	8808750	24860606	33669356	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		17336500	26
27 PROVISION FOR UNCOLLECTIBLE ACCOUNT	1266634		27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS		1266634	33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		18603134	40

STATEMENT OF REVENUES AND EXPENSES

DESCRIPTION			
1	TOTAL PATIENT REVENUES	33669356	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	16608132	2
3	NET PATIENT REVENUES	17061224	3
4	LESS - TOTAL OPERATING EXPENSES	18603134	4
5	NET INCOME FROM SERVICE TO PATIENTS	-1541910	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	125870	6
7	INCOME FROM INVESTMENTS	324004	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		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	92293	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	4429	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	TAX REVENUE	238377	24
24.01	RENTAL INCOME	51374	24.01
24.02	MISCELLANEOUS INCOME	132028	24.02
25	TOTAL OTHER INCOME	968375	25
26	TOTAL	-573535	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	-573535	31

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	0	4A	25	26	27	
GENERAL SERVICE COST CENTERS						
1 OLD CAP REL COSTS-BLDG & FIXT						1
2 OLD CAP REL COSTS-MVBLE EQUIP						2
3 NEW CAP REL COSTS-BLDG & FIXT						3
3.01 NEW CAP RHC REL COSTS-BLDG & FI						3.01
4 NEW CAP REL COSTS-MVBLE EQUIP						4
5 EMPLOYEE BENEFITS						5
6 ADMINISTRATIVE & GENERAL						6
7 MAINTENANCE & REPAIRS						7
8 OPERATION OF PLANT						8
8.01 RHC UTILITY EXPENSE						8.01
9 LAUNDRY & LINEN SERVICE						9
10 HOUSEKEEPING						10
11 DIETARY						11
12 CAFETERIA						12
13 MAINTENANCE OF PERSONNEL						13
14 NURSING ADMINISTRATION						14
15 CENTRAL SERVICES & SUPPLY						15
16 PHARMACY						16
17 MEDICAL RECORDS & LIBRARY						17
18 SOCIAL SERVICE						18
20 NONPHYSICIAN ANESTHETISTS						20
21 NURSING SCHOOL						21
22 I&R SERVICES-SALARY & FRINGES A						22
23 I&R SERVICES-OTHER PRGM COSTS A						23
24 PARAMED ED PRGM-(SPECIFY)						24
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS						25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM						37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC						41
44 LABORATORY						44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY						49
50 PHYSICAL THERAPY						50
53 ELECTROCARDIOLOGY						53
54 ELECTROENCEPHALOGRAPHY						54
55 MEDICAL SUPPLIES CHARGED TO PAT						55
56 DRUGS CHARGED TO PATIENTS						56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI						59
OUTPATIENT SERVICE COST CENTERS						
61 EMERGENCY						61
62 OBSERVATION BEDS (NON-DISTINCT						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
65 AMBULANCE SERVICES						65
69.10 CMHC						69.10
69.20 OUTPATIENT PHYSICAL THERAPY						69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY						69.30
69.40 OUTPATIENT SPEECH PATHOLOGY						69.40
71 HOME HEALTH AGENCY						71
SPECIAL PURPOSE COST CENTERS						
85.01 PANCREAS ACQUISITION						85.01
85.02 INTESTINAL ACQUISITION						85.02
85.03 ISLET CELL ACQUISITION						85.03
95 SUBTOTALS						95
NONREIMBURSABLE COST CENTERS						
96 GIFT, FLOWER, COFFEE SHOP & CAN						96
98 PHYSICIANS' PRIVATE OFFICES						98
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 TOTAL						103
104 TOTAL STATISTICAL BASIS						104
105 UNIT COST MULTIPLIER						105
105 UNIT COST MULTIPLIER						105

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-1

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	565046	565046		565046	-62070	502976	1
2	PHYSICIAN ASSISTANT							2
3	NURSE PRACTITIONER	180231	180231		180231		180231	3
4	VISITING NURSE							4
5	OTHER NURSE	204989	204989		204989		204989	5
6	CLINICAL PSYCHOLOGIST							6
7	CLINICAL SOCIAL WORKER							7
8	LABORATORY TECHNICIAN							8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	19939	19939		19939		19939	9
10	SUBTOTAL (SUM OF LINES 1-9)	970205	970205		970205	-62070	908135	10
COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT		231414	57923	289337		289337	11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13	OTHER COSTS UNDER AGREEMENT							13
14	SUBTOTAL (SUM OF LINES 11-13)		231414	57923	289337		289337	14
OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		14918		14918		14918	15
16	TRANSPORTATION (HEALTH CARE STAFF)							16
17	DEPRECIATION-MEDICAL EQUIPMENT							17
18	PROFESSIONAL LIABILITY INSURANCE		28044		28044		28044	18
19	OTHER HEALTH CARE COSTS		169014		169014		169014	19
20	ALLOWABLE GME COSTS							20
21	SUBTOTAL (SUM OF LINES 15-20)		211976		211976		211976	21
22	TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES	970205	443390	57923	1471518	-62070	1409448	22
23	PHARMACY							23
24	DENTAL							24
25	OPTOMETRY							25
26	ALL OTHER NONREIMBURSABLE COSTS							26
27	NONALLOWABLE GME COSTS							27
28	TOTAL NONREIMBURSABLE COSTS							28
FACILITY OVERHEAD								
29	FACILITY COSTS	246612	246612		246612		246612	29
30	ADMINISTRATIVE COSTS							30
31	TOTAL FACILITY OVERHEAD	246612	246612		246612		246612	31
32	TOTAL FACILITY COSTS	1216817	443390	57923	1718130	-62070	1656060	32

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2008 TO 02/28/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2009.01
 07/02/2009 09:11

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1 PHYSICIANS	1.97	9045	4200	8274		1
2 PHYSICIAN ASSISTANTS			2100			2
3 NURSE PRACTITIONERS	1.95	7531	2100	4095		3
4 SUBTOTAL	3.92	16576		12369	16576	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	3.92	16576			16576	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS					2476	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					1409448	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					1409448	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					246612	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					1270431	15
16 TOTAL OVERHEAD					1517043	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					1517043	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					1517043	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					2926491	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-3

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] FQHC [XX] TITLE XVIII
 [] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	2926491	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	7737	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	2918754	3
4	TOTAL VISITS	16576	4
5	PHYSICIANS VISITS UNDER AGREEMENT	2476	5
6	TOTAL ADJUSTED VISITS	19052	6
7	ADJUSTED COST PER VISIT	153.20	7

CALCULATION OF LIMIT(1)
 PRIOR TO ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

8	PER VISIT PAYMENT LIMIT	100.88	100.88	8
9	RATE FOR PROGRAM COVERED VISITS	153.20	153.20	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	5490	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	841068	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES		14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST		15
16	TOTAL PROGRAM COST	841068	16
16.01	PRIMARY PAYOR PAYMENTS	275	16.01
17	LESS: BENEFICIARY DEDUCTIBLE	56491	17
18	NET PROGRAM COST EXCLUDING VACCINES	784302	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE	627442	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION	7737	20
21	TOTAL REIMBURSABLE PROGRAM COST	635179	21
22	REIMBURSABLE BAD DEBTS	2616	22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		22.01
23	OTHER ADJUSTMENTS		23
24	NET REIMBURSABLE AMOUNT	637795	24
25	INTERIM PAYMENTS	373364	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		25.01
26	BALANCE DUE COMPONENT/PROGRAM	264431	26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		27

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2008 TO 02/28/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2009.01
 07/02/2009 09:11

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [XX] RHC [] TITLE V
 APPLICABLE BOX: [] PQHC [XX] TITLE XVIII
 [] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	908135	908135	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000062	0.000872	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	56	792	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	392	2486	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUSNZA VACCINE	448	3278	5
6 TOTAL DIRECT COST OF THE FACILITY	1409448	1409448	6
7 TOTAL OVERHEAD	1517043	1517043	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.000318	0.002326	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	482	3529	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	930	6807	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	8	113	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	116.25	60.24	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	8	113	13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	930	6807	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		7737	15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		7737	16

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2008 TO 02/28/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01
 07/02/2009 09:11

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

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-5

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		373364	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 A ZERO.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM			3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .01		3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .02		3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .03	NONE	3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	TO .04		3.05
	PROVIDER .05		3.50
	TO .50		3.51
	PROVIDER .51	NONE	3.52
	TO .52		3.53
	PROGRAM .53		3.54
	PROGRAM .54		
SUBTOTAL	.99		3.99
4 TOTAL INTERIM PAYMENTS		373364	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01		5.01
	TO .02		5.02
	PROVIDER .03		5.03
	PROVIDER .50		5.50
	TO .51		5.51
	PROGRAM .52		5.52
SUBTOTAL	.99		5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01		6.01
	PROVIDER TO .02		6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY			7
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____	
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____	

***** REPORT 97 ***** UTILIZATION STATISTICS *****

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	70.46		9.35				79.81 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
37 OPERATING ROOM	12.61	35.98					48.59 37
41 RADIOLOGY-DIAGNOSTIC	8.00	35.87					43.87 41
44 LABORATORY	10.94	36.82					47.76 44
49 RESPIRATORY THERAPY	47.56	31.83					79.39 49
50 PHYSICAL THERAPY	7.05	30.53					37.58 50
53 ELECTROCARDIOLOGY	9.36	38.86					48.22 53
54 ELECTROENCEPHALOGRAPHY	0.57	33.02					33.59 54
55 MEDICAL SUPPLIES CHARGED TO PAT	33.27	16.53					49.80 55
56 DRUGS CHARGED TO PATIENTS	42.10	14.62					56.72 56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI		94.83					94.83 59
61 EMERGENCY		34.76					34.76 61
62 OBSERVATION BEDS (NON-DISTINCT	0.72	28.02					28.74 62
101 TOTAL CHARGES	13.17	28.60					41.77 101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	579589	3.70	-579589	-7.70			3
3.01 NEW CAP RHC REL COSTS-BLDG & FI	193249	1.23	-193249	-2.57			3.01
4 NEW CAP REL COSTS-MVBLE EQUIP	727700	4.65	-727700	-9.67			4
5 EMPLOYEE BENEFITS	2831938	18.09	-2831938	-37.64			5
6 ADMINISTRATIVE & GENERAL	1556854	9.95	-1556854	-20.69			6
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	486873	3.11	-486873	-6.47			8
8.01 RHC UTILITY EXPENSE	26931	.17	-26931	-.36			8.01
9 LAUNDRY & LINEN SERVICE	70992	.45	-70992	-.94			9
10 HOUSEKEEPING	214884	1.37	-214884	-2.86			10
11 DIETARY	196760	1.26	-196760	-2.62			11
12 CAFETERIA							12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION	189230	1.21	-189230	-2.52			14
15 CENTRAL SERVICES & SUPPLY	22069	.14	-22069	-.29			15
16 PHARMACY	154507	.99	-154507	-2.05			16
17 MEDICAL RECORDS & LIBRARY	272209	1.74	-272209	-3.62			17
18 SOCIAL SERVICE							18
20 NONPHYSICIAN ANESTHETISTS							20
21 NURSING SCHOOL							21
22 I&R SERVICES-SALARY & FRINGES A							22
23 I&R SERVICES-OTHER PRGM COSTS A							23
24 PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS							
25 ADULTS & PEDIATRICS	926842	5.92	1405365	18.68	2332207	14.90	25
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	520964	3.33	700036	9.30	1221000	7.80	37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	861585	5.50	1059592	14.08	1921177	12.27	41
44 LABORATORY	1033719	6.60	574622	7.64	1608341	10.28	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	181715	1.16	177762	2.36	359477	2.30	49
50 PHYSICAL THERAPY	450658	2.88	440423	5.85	891081	5.69	50
53 ELECTROCARDIOLOGY	36244	.23	44661	.59	80905	.52	53
54 ELECTROENCEPHALOGRAPHY	10225	.07	24683	.33	34908	.22	54
55 MEDICAL SUPPLIES CHARGED TO PAT	336038	2.15	60791	.81	396829	2.54	55
56 DRUGS CHARGED TO PATIENTS	363820	2.32	344884	4.58	708704	4.53	56
59 PSYCHIATRIC/PSYCHOLOGICAL SERVI	450267	2.88	183621	2.44	633888	4.05	59
61 EMERGENCY	874815	5.59	660118	8.77	1534933	9.81	61
62 OBSERVATION BEDS (NON-DISTINCT							62
63.50 RHC	1656060	10.58	1270431	16.89	2926491	18.70	63.50
63.60 PQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65 AMBULANCE SERVICES	391209	2.50	418350	5.56	809559	5.17	65

PROVIDER NO. 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2008 TO 02/28/2009

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
OUTPATIENT SERVICE COST CENTERS							
69.10							69.10
69.20							69.20
69.30							69.30
69.40							69.40
71							71
SPECIAL PURPOSE COST CENTERS							
85.01							85.01
85.02							85.02
85.03							85.03
NONREIMBURSABLE COST CENTERS							
96			11662	.16	11662	.07	96
98	34742	.22	146784	1.95	181526	1.16	98
101							101
102							102
103	15652688	100.00	0	.00	15652688	100.00	103

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	3213415
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	8310043
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.387