

CLAY COUNTY HOSPITAL
FLORA, ILLINOIS
MEDICARE COST REPORT
YEAR ENDED FEBRUARY 28, 2013

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

WORKSHEET S
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1. ELECTRONICALLY FILED COST REPORT DATE: 07/15/2013 TIME: 17:20
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR 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 03/01/2012 AND ENDING 02/28/2013, AND 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: 07/15/2013 17:20
 PpN:up0qM.iYxa:mSSpAlYxIa.LCn0
 ongPp03Oqbgj7IA34X8wPum.cN8Nh
 2qp40AuZnS07MGRx

(SIGNED) _____
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PI Encryption: 07/15/2013 17:20
 euJx:abrIipOi46kbyj8GiONOHgB0
 8mJvd0iFIXs2QqW8cOzE5ieYzj3bk9
 tQjC0rJ0sl0jBVm.

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1	HOSPITAL					1
2	SUBPROVIDER - IPF	103,399	25,814		240,036	2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF	149,737				5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC		127,483			10
10.01	HEALTH CLINIC - RHC II					10.01
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	253,136	153,297		240,036	200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO 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 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 911 STACY BURK DRIVE
 2 CITY: FLORA

STATE: IL

P.O. BOX:
 ZIP CODE: 62839-0280 COUNTY: CLAY

1
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)		
						V 6	XVIII 7	XIX 8
3	HOSPITAL	14-1351	99914	1	12/21/2005	N	O	O
4	SUBPROVIDER - IPF							
5	SUBPROVIDER - IRF							
6	SUBPROVIDER - (OTHER)							
7	SWING BEDS - SNF	14-2351	99914		12/21/2005	N	O	N
8	SWING BEDS - NF							
9	HOSPITAL-BASED SNF							
10	HOSPITAL-BASED NF							
11	HOSPITAL-BASED OLTC							
12	HOSPITAL-BASED HHA							
13	SEPARATELY CERTIFIED ASC							
14	HOSPITAL-BASED HOSPICE							
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-3458	99914		11/29/2005	N	O	N
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	14-3487	99914		12/18/2006	N	O	N
16	HOSPITAL-BASED HEALTH CLINIC - FQHC							
17	HOSPITAL-BASED (CMHC)							
18	RENAL DIALYSIS							
19	OTHER							
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 03/01/2012			TO: 02/28/2013			
21	TYPE OF CONTROL				9			

INPATIENT PPS INFORMATION

	IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID UNPAID DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID UNPAID DAYS 4	OTHER MEDICAID HMO PAID DAYS 5	OTHER MEDICAID DAYS 6	1	2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.						3	N
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.							2
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.							2
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. BEGINNING: ENDING:							
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. BEGINNING: ENDING:							
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)						N	N

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

	V	XVIII	XIX
45	1	2	3
45	N	N	N
46	N	N	N
47	N	N	N
48	N	N	N

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	56
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N			58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER \$413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)					
PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))	
1	2	3	4	5	
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4)). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))		
1	2	3	4	5		
INPATIENT PSYCHIATRIC FACILITY PPS						
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	70		
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71		
INPATIENT REHABILITATION FACILITY PPS						
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	75		
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76		
LONG TERM CARE HOSPITAL PPS						
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	80		
TEFRA PROVIDERS						
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.		N	85		
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	86		
TITLE V AND XIX INPATIENT SERVICES						
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.		N	90		
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	91		
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92		
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	93		
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	94		
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95		
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	96		
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97		
RURAL PROVIDERS						
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?		Y	105		
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.		Y	106		
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. 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, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.		N	107		
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.		N	108		
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- SICAL N	OCUP- ATIONAL N	RESPI- RATORY N	109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 67,000 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 N	2	140
IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.				
141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	Y	01/04/2013	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)		TITLE XVIII PART A	TITLE XVIII PART B	TITLE V	TITLE XIX
155	HOSPITAL	1 N	2 N	3 N	4 N
156	SUBPROVIDER - IPF	N	N		156
157	SUBPROVIDER - IRF	N	N		157
158	SUBPROVIDER - (OTHER)	N	N		158
159	SNF	N	N		159
160	HHA	N	N		160
161	CMHC		N		161

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
PERIOD FROM 03/01/2012 TO 02/28/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
ENTER 'Y' FOR YES OR 'N' FOR NO.

166 IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN
COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.

NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167 IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO. N 167

168 IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'),
ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS. 168

169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH
(LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR. 169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	N	2	1	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N	2	3	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	3	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		2	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y 12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	05/15/2013	Y	05/15/2013
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COST

22	HAVE ASSETS BEEN RELIEF FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27

INTEREST EXPENSE

28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31

PURCHASED SERVICES

32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33

PROVIDER-BASED PHYSICIANS

34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	35

HOME OFFICE COSTS

		Y/N	DATE
		1	2
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	N	
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		36
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.	N	38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		40

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: MARK	LAST NAME: W	TITLE: DALLAS	41
42	EMPLOYER: KERBER, ECK, & BRAECKEL			42
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: MARKD@KEBCPA.COM		43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE NO.	COMPONENT	WKST A	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS							
			NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS		
1			2	3	4	5	6	7	8	9
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	22	8,030	192,720.00		2,163	290	3,119	1
2	HMO									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						614		614	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		22	8,030	192,720.00		2,777	290	3,733	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)		22	8,030	192,720.00		2,777	290	3,733	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88					6,543		23,240	26
26.01	RHC II	88.01								26.01
27	TOTAL (SUM OF LINES 14-26)		22							27
28	OBSERVATION BED DAYS							17	90	28
29	AMBULANCE TRIPS						892			29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTC NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

LINE NO.	COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			DISCHARGES			TOTAL ALL PATIENTS 15	
			TOTAL INTERNS & RESIDENTS 9	EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14		
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					665	103	950	1
2	HMO									2
3	HMO IPF									3
4	HMO IRF									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (SEE INSTRUCTIONS)			155.50			665	103	950	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88		27.80						26
26.01	RHC II	88.01								26.01
27	TOTAL (SUM OF LINES 14-26)			183.30						27
28	OBSERVATION BED DAYS									28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)									32
33	LTCH NON-COVERED DAYS									33

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
1	2	3	4	5	6
SALARIES					
1	200				1
2					2
3					3
4					4
4.01					4.01
5					5
6					6
7	21				7
7.01					7.01
8					8
9	44				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
22.01					22.01
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					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	5
6	TOTAL (SUM OF LINES 3 THRU 5)	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
 PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
 PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT LABOR	BENEFIT COST
0		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTG		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II		14.01
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	01/25/1985	2

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

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PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OCT 1 OF THE COST REPORTING PERIOD (IF APPLICABLE) 2
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SNF SERVICES

201 ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY,
 IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN
 EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE). 201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING
 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207:
 ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY
 TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS
 INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 3
---------------	-----------------	--

202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)			207

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.441347	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,710,737	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				8,524,717	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				3,762,358	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				2,051,621	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE				120,854	17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS				228,241	18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				2,051,621	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	646,652	146,021	792,673		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	285,398	64,446	349,844		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	281,459	62,628	344,087		22
23	COST OF CHARITY CARE	3,939	1,818	5,757		23
24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)				2,750,981	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V				635,764	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)				2,115,217	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)				933,545	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)				939,302	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)				2,990,923	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		929,486	929,486	-185,548	1
1.01	00101		3,559	3,559	180,234	1.01
2	00200		963,569	963,569	5,314	2
3	00300					3
4	00400	92,121	3,291,245	3,383,366		4
5	00500	894,669	1,439,991	2,334,660		5
6	00600					6
7	00700	149,886	334,868	484,754		7
7.01	00701		33,798	33,798		7.01
8	00800		72,981	72,981		8
9	00900	202,020	53,096	255,116		9
10	01000	199,741	155,836	355,577	-255,084	10
11	01100				255,084	11
12	01200					12
13	01300	406,843	32,642	439,485		13
14	01400	24,930	14,100	39,030		14
15	01500	168,364	45,966	214,330		15
16	01600	274,417	38,368	312,785		16
17	01700					17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,224,568	43,947	1,268,515		30
ANCILLARY SERVICE COST CENTERS						
50	05000	334,771	130,921	465,692	5,566	50
53	05300		218,343	218,343	-5,566	53
54	05400	379,165	634,535	1,013,700		54
60	06000	466,637	892,807	1,359,444		60
62.30	06250					62.30
65	06500	273,164	33,854	307,018	-54,633	65
66	06600	340,514	25,497	366,011		66
69	06900	21,380	6,768	28,148	40,975	69
70	07000		39,877	39,877	13,658	70
71	07100		337,016	337,016	-16,059	71
72	07200				16,059	72
73	07300		526,060	526,060		73
76	03550		465,487	465,487		76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	2,021,996	207,591	2,229,587		88
90	09000		27,446	27,446		90
91	09100	729,571	1,550,846	2,280,417		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	454,858	97,516	552,374		95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
118		8,659,615	12,648,016	21,307,631		118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	32,323	14,874	47,197		192
200		8,691,938	12,662,890	21,354,828		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	743,938		690,937	1
1.01	00101	183,793	-53,001	183,793	1.01
2	00200	968,883		968,883	2
3	00300				3
4	00400	3,383,366		3,357,937	4
5	00500	2,334,660	-25,429	2,175,418	5
6	00600				6
7	00700	484,754		484,754	7
7.01	00701	33,798		33,798	7.01
8	00800	72,981		72,981	8
9	00900	255,116		255,116	9
10	01000	100,493		100,493	10
11	01100	255,084	-109,000	146,084	11
12	01200				12
13	01300	439,485		439,485	13
14	01400	39,030		39,030	14
15	01500	214,330		214,330	15
16	01600	312,785	-6,108	306,677	16
17	01700				17
19	01900				19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,268,515		1,268,515	30
ANCILLARY SERVICE COST CENTERS					
50	05000	471,258		471,258	50
53	05300	212,777	-212,777		53
54	05400	1,013,700		1,013,700	54
60	06000	1,359,444		1,359,444	60
62.30	06250				62.30
65	06500	252,385	-1,771	250,614	65
66	06600	366,011		366,011	66
69	06900	69,123	-21,380	47,743	69
70	07000	53,535	-39,500	14,035	70
71	07100	320,957	-402	320,555	71
72	07200	16,059		16,059	72
73	07300	526,060		526,060	73
76	03550	465,487		465,487	76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
88	08800	2,229,587	-59,792	2,169,795	88
90	09000	27,446		27,446	90
91	09100	2,280,417	-1,079,474	1,200,943	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
95	09500	552,374		552,374	95
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
SPECIAL PURPOSE COST CENTERS					
118		21,307,631	-1,767,876	19,539,755	118
SUBTOTALS (SUM OF LINES 1-117)					
NONREIMBURSABLE COST CENTERS					
190	19000				190
192	19200	47,197		47,197	192
200		21,354,828	-1,767,876	19,586,952	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER
			LINE #	SALARY	
1	1	2	3	4	5
1 DEPRICIATION	A	NEW CAP RHC REL COSTS-BLDG &	1.01		174,768 1
500 TOTAL RECLASSIFICATIONS					174,768 500
CODE LETTER - A					
1 RESPIRATORY THERAPY	B	ELECTROCARDIOLOGY	69	40,975	1
2		ELECTROENCEPHALOGRAPHY	70	13,658	2
500 TOTAL RECLASSIFICATIONS				54,633	500
CODE LETTER - B					
1 INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	1.01		5,466 1
2		CAP REL COSTS-MVBLE EQUIP	2		5,314 2
500 TOTAL RECLASSIFICATIONS					10,780 500
CODE LETTER - C					
1 OPERATING ROOM	D	OPERATING ROOM	50		5,566 1
500 TOTAL RECLASSIFICATIONS					5,566 500
CODE LETTER - D					
1 RECLASS PORTION OF DIETARY TO CAFE	E	CAFETERIA	11	143,290	111,794 1
500 TOTAL RECLASSIFICATIONS				143,290	111,794 500
CODE LETTER - E					
1 RECLASS IMPLANTABLE DEVICE COST	F	IMPL. DEV. CHARGED TO PATIENT	72		16,059 1
500 TOTAL RECLASSIFICATIONS					16,059 500
CODE LETTER - F					
GRAND TOTAL (INCREASES)				197,923	318,967

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE	SALARY	OTHER	WKST A-7	
			LINE #			REF.	
	1	6	7	8	9	10	
1 DEPRICIATION	A	CAP REL COSTS-BLDG & FIXT	1		174,768		9 1
500 TOTAL RECLASSIFICATIONS					174,768		500
1 RESPIRATORY THERAPY	B	RESPIRATORY THERAPY	65	54,633			1 2
500 TOTAL RECLASSIFICATIONS				54,633			500
1 INSURANCE EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		10,780		12 1
500 TOTAL RECLASSIFICATIONS					10,780		12 2 500
1 OPERATING ROOM	D	ANESTHESIOLOGY	53		5,566		1 1
500 TOTAL RECLASSIFICATIONS					5,566		500
1 RECLASS PORTION OF DIETARY TO CAFE	E	DIETARY	10	143,290	111,794		1 1
500 TOTAL RECLASSIFICATIONS				143,290	111,794		500
1 RECLASS IMPLANTABLE DEVICE COST	F	MEDICAL SUPPLIES CHRGED TO PA	71		16,059		1 1
500 TOTAL RECLASSIFICATIONS					16,059		500
CODE LETTER - F							
GRAND TOTAL (DECREASES)				197,923	318,967		

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN 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	132,111					132,111		1
2 LAND IMPROVEMENTS	345,852					345,852		2
3 BUILDINGS AND FIXTURES	12,306,190	294,107		294,107	105,611	12,494,686		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT	7,596,513	274,514		274,514	98,716	7,772,311		6
7 HIT DESIGNATED ASSETS								7
8 SUBTOTAL (SUM OF LINES 1-7)	20,380,666	568,621		568,621	204,327	20,744,960		8
9 RECONCILING ITEMS								9
10 TOTAL (LINE 7 MINUS LINE 9)	20,380,666	568,621		568,621	204,327	20,744,960		10

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

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	623,304		269,683	36,499			929,486 1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT					3,559		3,559 1.01
2 CAP REL COSTS-MVBLE EQUIP	782,445	181,124					963,569 2
3 TOTAL (SUM OF LINES 1-2)	1,405,749	181,124	269,683	36,499	3,559		1,896,614 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	COMPUTATION OF RATIOS		INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
			FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4				(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	12,972,649		12,972,649	0.625340				1
1.01 NEW CAP RHC REL COSTS-BLDG & FIX								1.01
2 CAP REL COSTS-MVBLE EQUIP	7,772,311		7,772,311	0.374660				2
3 TOTAL (SUM OF LINES 1-2)	20,744,960		20,744,960	1.000000				3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	448,536		216,682	25,719			690,937 1
1.01 NEW CAP RHC REL COSTS-BLDG & FIX	174,768			5,466	3,559		183,793 1.01
2 CAP REL COSTS-MVBLE EQUIP	782,445	181,124		5,314			968,883 2
3 TOTAL	1,405,749	181,124	216,682	36,499	3,559		1,843,613 3

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-BUILDINGS & FIXTURES (CHAPTER 2)	B	-53,001	CAP REL COSTS-BLDG & FIXT	1	11 1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)					3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)	B	-301	ADMINISTRATIVE & GENERAL	5	4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-3,208	ADMINISTRATIVE & GENERAL	5	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,168,417			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)	B	-3,152	ADMINISTRATIVE & GENERAL	5	11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-109,000	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-402	MEDICAL SUPPLIES CHRGD TO PATI	71	16
17 SALE OF DRUGS TO OTHER THAN PATIENTS					17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-6,108	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION, FEES, BOOKS, ETC.)					19
20 VENDING MACHINES	B	-299	ADMINISTRATIVE & GENERAL	5	20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 EKG PHYSICIAN EMPLOYEE BENEFITS	A	-18,724	EMPLOYEE BENEFITS	4	33
34 MISCELLANEOUS REVENUE	B	-17,933	ADMINISTRATIVE & GENERAL	5	34
35 PUBLIC RELATIONS	A	-127,536	ADMINISTRATIVE & GENERAL	5	35
36 LOBBYING EXPENSE	A	-6,813	ADMINISTRATIVE & GENERAL	5	36
37 CRNA EXPENSE	A	-212,777	ANESTHESIOLOGY	53	37
38 EMPLOYEE BENEFITS LAB TESTS	A	-6,705	EMPLOYEE BENEFITS	4	38
39 PHYSICIAN CLINIC EXPENSE	A	-33,500	RURAL HEALTH CLINIC (RHC)	88	39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49)		-1,767,876			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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 (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4)					
	TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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.

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP		RELATED ORGANIZATION(S) AND/OR HOME OFFICE	
		3	4	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6					
7					
8					
9					
10					

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2012 TO 02/28/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM VERSION: 2012.11
 IN LIEU OF FORM CMS-2552-10 (08/2011) 07/15/2013 16:26

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2		3	4	5	6	7	8	9
1	60	LABORATORY	25,500		25,500				1
2	65	RESPIRATORY THERAPY	1,771	1,771					2
3	69	ELECTROCARDIOLOGY	21,380	21,380					3
4	70	ELECTROENCEPHALOGRAPHY	39,500	39,500					4
5	88	RURAL HEALTH CLINIC (RHC)	26,292	26,292					5
6	91	EMERGENCY	1,453,892	1,079,474	374,418				6
200		TOTAL	1,568,335	1,168,417	399,918				200

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2012 TO 02/28/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM VERSION: 2012.11
 IN LIEU OF FORM CMS-2552-10 (08/2011) 07/15/2013 16:26

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.			12	13	14	15	16	17	18	
1	60	LABORATORY								1
2	65	RESPIRATORY THERAPY	AGGREGATE						1,771	2
3	69	ELECTROCARDIOLOGY	AGGREGATE						21,380	3
4	70	ELECTROENCEPHALOGRAPHY	AGGREGATE						39,500	4
5	88	RURAL HEALTH CLINIC (RHC)	AGGREGATE						26,292	5
6	91	EMERGENCY	AGGREGATE						1,079,474	6
200		TOTAL							1,168,417	200

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	NEW RHC BUILDING FIXTURES 1.01	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	690,937	690,937				1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT	183,793		183,793			1.01
2 CAP REL COSTS-MVBLE EQUIP	968,883			968,883		2
4 EMPLOYEE BENEFITS	3,357,937				3,357,937	4
5 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	2,175,418	301,523		422,818	349,338	5
6 OPERATION OF PLANT	484,754	5,219		7,319	58,525	6
7 RHC UTILITY EXPENSE	33,798					7
7.01 LAUNDRY & LINEN SERVICE	72,981					7.01
8 HOUSEKEEPING	255,116	3,800		5,329	78,882	8
9 DIETARY	100,493	16,074		22,540	22,042	9
10 CAFETERIA	146,084				55,950	10
11 MAINTENANCE OF PERSONNEL						11
12 NURSING ADMINISTRATION	439,485	3,267		4,581	158,858	12
13 CENTRAL SERVICES & SUPPLY	39,030	5,675		7,957	9,734	13
14 PHARMACY	214,330	5,466		7,665	65,740	14
15 MEDICAL RECORDS & LIBRARY	306,677	42,833		60,064	107,151	15
16 SOCIAL SERVICE						16
17 NONPHYSICIAN ANESTHETISTS						17
19 NURSING SCHOOL						19
20 I&R SRVCES-SALARY & FRINGES APPRVD						20
21 I&R SRVCES-OTHER PRGM COSTS APPRVD						21
22 PARAMED ED PRGM-(SPECIFY)						22
23 INPATIENT ROUTINE SERV COST CENTERS						23
30 ADULTS & PEDIATRICS	1,268,515	79,497		111,476	478,152	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	471,258	52,933		74,226	130,717	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,013,700	39,098		54,826	148,051	54
60 LABORATORY	1,359,444	15,592		21,865	182,206	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	250,614	4,373		6,132	85,329	65
66 PHYSICAL THERAPY	366,011		45,793		132,959	66
69 ELECTROCARDIOLOGY	47,743	4,373		6,132	24,348	69
70 ELECTROENCEPHALOGRAPHY	14,035	4,360		6,114	5,333	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	320,555					71
72 IMPL. DEV. CHARGED TO PATIENT	16,059					72
73 DRUGS CHARGED TO PATIENTS	526,060					73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	465,487	33,605		47,124		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	2,169,795		127,381		789,521	88
90 CLINIC	27,446					90
91 EMERGENCY	1,200,943	36,377		51,011	284,873	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	552,374	16,191		22,704	177,607	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	19,539,755	670,256	173,174	939,883	3,345,316	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,501		4,909		190
192 PHYSICIANS' PRIVATE OFFICES	47,197	17,180	10,619	24,091	12,621	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	19,586,952	690,937	183,793	968,883	3,357,937	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SUBTOTAL (COLS. 0-4) 4A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	RHC UTILITY EXPENSE 7.01	LAUNDRY & LINEN SERVICE 8	
GENERAL SERVICE COST CENTERS						1
1 CAP REL COSTS-BLDG & FIXT						1.01
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						2
2 CAP REL COSTS-MVBLE EQUIP						4
4 EMPLOYEE BENEFITS						5
5 ADMINISTRATIVE & GENERAL	3,249,097	3,249,097				6
6 MAINTENANCE & REPAIRS						7
7 OPERATION OF PLANT	555,817	110,535	666,352			7.01
7.01 RHC UTILITY EXPENSE	33,798	6,721		40,519		8
8 LAUNDRY & LINEN SERVICE	72,981	14,514			87,495	9
9 HOUSEKEEPING	343,127	68,237	6,592			10
10 DIETARY	161,149	32,048	27,878			11
11 CAFETERIA	202,034	40,178				12
12 MAINTENANCE OF PERSONNEL						13
13 NURSING ADMINISTRATION	606,191	120,553	5,666			14
14 CENTRAL SERVICES & SUPPLY	62,396	12,409	9,842			15
15 PHARMACY	293,201	58,309	9,481			16
16 MEDICAL RECORDS & LIBRARY	516,725	102,761	74,290			17
17 SOCIAL SERVICE						19
19 NONPHYSICIAN ANESTHETISTS						20
20 NURSING SCHOOL						21
21 I&R SRVCES-SALARY & FRINGES APRVD						22
22 I&R SRVCES-OTHER PRGM COSTS APRVD						23
23 PARAMED ED PRGM-(SPECIFY)						30
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,937,640	385,337	137,881		87,495	50
ANCILLARY SERVICE COST CENTERS						53
50 OPERATING ROOM	729,134	145,002	91,807			54
53 ANESTHESIOLOGY						60
54 RADIOLOGY-DIAGNOSTIC	1,255,675	249,715	67,811			62.30
60 LABORATORY	1,579,107	314,035	27,043			65
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						66
65 RESPIRATORY THERAPY	346,448	68,898	7,585			69
66 PHYSICAL THERAPY	544,763	108,336		10,096		70
69 ELECTROCARDIOLOGY	82,596	16,426	7,585			71
70 ELECTROENCEPHALOGRAPHY	29,842	5,935	7,562			72
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	320,555	63,748				73
72 IMPL. DEV. CHARGED TO PATIENT	16,059	3,194				76
73 DRUGS CHARGED TO PATIENTS	526,060	104,617				76.97
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	546,216	108,625	58,285			76.98
76.97 CARDIAC REHABILITATION						76.99
76.98 HYPERBARIC OXYGEN THERAPY						
76.99 LITHOTRIPSY						88
OUTPATIENT SERVICE COST CENTERS						90
88 RURAL HEALTH CLINIC (RHC)	3,086,697	613,851		28,082		91
90 CLINIC	27,446	5,458				92
91 EMERGENCY	1,573,204	312,862	63,093			95
92 OBSERVATION BEDS						99.10
OTHER REIMBURSABLE COST CENTERS						99.20
95 AMBULANCE SERVICES	768,876	152,906	28,082			99.30
99.10 CORF						99.40
99.20 OUTPATIENT PHYSICAL THERAPY						
99.30 OUTPATIENT OCCUPATIONAL THERAPY						
99.40 OUTPATIENT SPEECH PATHOLOGY						
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	19,466,834	3,225,210	630,483	38,178	87,495	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,410	1,672	6,072			192
192 PHYSICIANS' PRIVATE OFFICES	111,708	22,215	29,797	2,341		200
200 CROSS FOOT ADJUSTMENTS						201
201 NEGATIVE COST CENTER						202
202 TOTAL (SUM OF LINES 118-201)	19,586,952	3,249,097	666,352	40,519	87,495	

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING 9	DIETARY 10	CAFETERIA 11	NURSING ADMINIS-TRATION 13	CENTRAL SERVICES & SUPPLY 14	
GENERAL SERVICE COST CENTERS						1
1 CAP REL COSTS-BLDG & FIXT						1.01
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						2
2 CAP REL COSTS-MVBLE EQUIP						4
4 EMPLOYEE BENEFITS						5
5 ADMINISTRATIVE & GENERAL						6
6 MAINTENANCE & REPAIRS						7
7 OPERATION OF PLANT						7.01
7.01 RHC UTILITY EXPENSE						8
8 LAUNDRY & LINEN SERVICE						9
9 HOUSEKEEPING	417,956					10
10 DIETARY	17,661	238,736				11
11 CAFETERIA			242,212			12
12 MAINTENANCE OF PERSONNEL						13
13 NURSING ADMINISTRATION	3,589		13,775	749,774		14
14 CENTRAL SERVICES & SUPPLY	6,235		844	4,792	96,518	15
15 PHARMACY	6,006		5,701	32,361	977	16
16 MEDICAL RECORDS & LIBRARY	47,062		9,291			17
17 SOCIAL SERVICE						19
19 NONPHYSICIAN ANESTHETISTS						20
20 NURSING SCHOOL						21
21 I&R SRVCES-SALARY & FRINGES APPRVD						22
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						23
23 PARAMED ED PRGM-(SPECIFY)						30
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	87,348	238,736	41,463	205,891	1,651	50
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	58,159		11,335	64,345	25,538	53
53 ANESTHESIOLOGY						54
54 RADIOLOGY-DIAGNOSTIC	42,958		12,838	72,878	6,088	60
60 LABORATORY	17,132		15,800	89,690	48,007	62.30
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						65
65 RESPIRATORY THERAPY	4,805		7,399	52,163	1,007	66
66 PHYSICAL THERAPY			11,529		481	69
69 ELECTROCARDIOLOGY	4,805		2,111		11	70
70 ELECTROENCEPHALOGRAPHY	4,791		462		7	71
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					6,974	72
72 IMPL. DEV. CHARGED TO PATIENT					1,651	73
73 DRUGS CHARGED TO PATIENTS						76
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	36,923					76.97
76.97 CARDIAC REHABILITATION						76.98
76.98 HYPERBARIC OXYGEN THERAPY						76.99
76.99 LITHOTRIPSY						88
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			68,466		1,062	90
90 CLINIC						91
91 EMERGENCY	39,969		24,703	140,228	2,748	92
92 OBSERVATION BEDS						95
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	17,790		15,401	87,426	312	99.10
99.10 CORF						99.20
99.20 OUTPATIENT PHYSICAL THERAPY						99.30
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.40
99.40 OUTPATIENT SPEECH PATHOLOGY						118
118 SUBTOTALS (SUM OF LINES 1-117)	395,233	238,736	241,118	749,774	96,514	190
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,847					192
192 PHYSICIANS' PRIVATE OFFICES	18,876		1,094		4	200
200 CROSS FOOT ADJUSTMENTS						201
201 NEGATIVE COST CENTER						202
202 TOTAL (SUM OF LINES 118-201)	417,956	238,736	242,212	749,774	96,518	

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
1 GENERAL SERVICE COST CENTERS						1
1.01 CAP REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION						13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	406,036					15
16 MEDICAL RECORDS & LIBRARY		750,129				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS ADULTS & PEDIATRICS		40,895	3,164,337		3,164,337	30
50 ANCILLARY SERVICE COST CENTERS OPERATING ROOM		35,386	1,160,706		1,160,706	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		164,553	1,872,516		1,872,516	54
60 LABORATORY		153,800	2,244,614		2,244,614	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		8,437	496,742		496,742	65
66 PHYSICAL THERAPY		30,999	706,204		706,204	66
69 ELECTROCARDIOLOGY		10,294	123,828		123,828	69
70 ELECTROENCEPHALOGRAPHY		5,746	54,345		54,345	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		47,863	439,140		439,140	71
72 IMPL. DEV. CHARGED TO PATIENT		1,584	22,488		22,488	72
73 DRUGS CHARGED TO PATIENTS	406,036	95,360	1,132,073		1,132,073	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		16,231	766,280		766,280	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
88 OUTPATIENT SERVICE COST CENTERS RURAL HEALTH CLINIC (RHC)		41,986	3,840,144		3,840,144	88
90 CLINIC		1,413	34,317		34,317	90
91 EMERGENCY		72,137	2,228,944		2,228,944	91
92 OBSERVATION BEDS						92
95 OTHER REIMBURSABLE COST CENTERS AMBULANCE SERVICES		23,445	1,094,238		1,094,238	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
118 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	406,036	750,129	19,380,916		19,380,916	118
190 NONREIMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN			20,001		20,001	190
192 PHYSICIANS' PRIVATE OFFICES			186,035		186,035	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	406,036	750,129	19,586,952		19,586,952	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	NEW RHC BUILDING FIXTURES 1.01	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL		301,523		422,818	724,341	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		5,219		7,319	12,538	7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING		3,800		5,329	9,129	9
10 DIETARY		16,074		22,540	38,614	10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		3,267		4,581	7,848	13
14 CENTRAL SERVICES & SUPPLY		5,675		7,957	13,632	14
15 PHARMACY		5,466		7,665	13,131	15
16 MEDICAL RECORDS & LIBRARY		42,833		60,064	102,897	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		79,497		111,476	190,973	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		52,933		74,226	127,159	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		39,098		54,826	93,924	54
60 LABORATORY		15,592		21,865	37,457	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		4,373		6,132	10,505	65
66 PHYSICAL THERAPY			45,793		45,793	66
69 ELECTROCARDIOLOGY		4,373		6,132	10,505	69
70 ELECTROENCEPHALOGRAPHY		4,360		6,114	10,474	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		33,605		47,124	80,729	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			127,381		127,381	88
90 CLINIC						90
91 EMERGENCY		36,377		51,011	87,388	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		16,191		22,704	38,895	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)		670,256	173,174	939,883	1,783,313	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,501		4,909	8,410	190
192 PHYSICIANS' PRIVATE OFFICES		17,180	10,619	24,091	51,890	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		690,937	183,793	968,883	1,843,613	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	RHC UTILITY EXPENSE 7.01	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	724,341					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	24,642	37,180				7
7.01 RHC UTILITY EXPENSE	1,498		1,498			7.01
8 LAUNDRY & LINEN SERVICE	3,236			3,236		8
9 HOUSEKEEPING	15,213				24,710	9
10 DIETARY	7,145	1,556			1,044	10
11 CAFETERIA	8,957					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	26,875	316			212	13
14 CENTRAL SERVICES & SUPPLY	2,766	549			369	14
15 PHARMACY	12,999	529			355	15
16 MEDICAL RECORDS & LIBRARY	22,909	4,145			2,782	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	85,905	7,692		3,236	5,165	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	32,326	5,123			3,438	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	55,670	3,784			2,540	54
60 LABORATORY	70,010	1,509			1,013	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	15,360	423			284	65
66 PHYSICAL THERAPY	24,152		373			66
69 ELECTROCARDIOLOGY	3,662	423			284	69
70 ELECTROENCEPHALOGRAPHY	1,323	422			283	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	14,212					71
72 IMPL. DEV. CHARGED TO PATIENT	712					72
73 DRUGS CHARGED TO PATIENTS	23,323					73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	24,216	3,252			2,183	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	136,851		1,038			88
90 CLINIC	1,217					90
91 EMERGENCY	69,748	3,520			2,363	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	34,088	1,567			1,052	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	719,015	35,178	1,411	3,236	23,367	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	373	339			227	190
192 PHYSICIANS' PRIVATE OFFICES	4,953	1,663	87		1,116	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	724,341	37,180	1,498	3,236	24,710	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	48,359					10
11 CAFETERIA		8,957				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		509	35,760			13
14 CENTRAL SERVICES & SUPPLY		31	229	17,576		14
15 PHARMACY		211	1,543	178	28,946	15
16 MEDICAL RECORDS & LIBRARY		344				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	48,359	1,533	9,819	301		30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		419	3,069	4,650		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		475	3,476	1,109		54
60 LABORATORY		584	4,278	8,742		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		274	2,488	183		65
66 PHYSICAL THERAPY		426		88		66
69 ELECTROCARDIOLOGY		78		2		69
70 ELECTROENCEPHALOGRAPHY		17		1		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				1,270		71
72 IMPL. DEV. CHARGED TO PATIENT				301		72
73 DRUGS CHARGED TO PATIENTS					28,946	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		2,534		193		88
90 CLINIC						90
91 EMERGENCY		913	6,688	500		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		569	4,170	57		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	48,359	8,917	35,760	17,575	28,946	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES		40		1		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	48,359	8,957	35,760	17,576	28,946	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 16	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT					1.01
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
7.01 RHC UTILITY EXPENSE					7.01
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY	133,077				16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	7,254	360,237		360,237	30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	6,277	182,461		182,461	50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	29,206	190,184		190,184	54
60 LABORATORY	27,281	150,874		150,874	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	1,497	31,014		31,014	65
66 PHYSICAL THERAPY	5,499	76,331		76,331	66
69 ELECTROCARDIOLOGY	1,826	16,780		16,780	69
70 ELECTROENCEPHALOGRAPHY	1,019	13,539		13,539	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	8,490	23,972		23,972	71
72 IMPL. DEV. CHARGED TO PATIENT	281	1,294		1,294	72
73 DRUGS CHARGED TO PATIENTS	16,915	69,184		69,184	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,879	113,259		113,259	76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	7,447	275,444		275,444	88
90 CLINIC	251	1,468		1,468	90
91 EMERGENCY	12,796	183,916		183,916	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	4,159	84,557		84,557	95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	133,077	1,774,514		1,774,514	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		9,349		9,349	190
192 PHYSICIANS' PRIVATE OFFICES		59,750		59,750	192
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	133,077	1,843,613		1,843,613	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	NEW RHC BUILDING FIXTURES SQUARE FEET 1.01	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON-CILIATION 5A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	53,087					1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT		15,681				1.01
2 CAP REL COSTS-MVBLE EQUIP			53,087			2
4 EMPLOYEE BENEFITS				8,599,817		4
5 ADMINISTRATIVE & GENERAL	23,167		23,167	894,669	-3,249,097	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	401		401	149,886		7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING	292		292	202,020		9
10 DIETARY	1,235		1,235	56,451		10
11 CAFETERIA				143,290		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	251		251	406,843		13
14 CENTRAL SERVICES & SUPPLY	436		436	24,930		14
15 PHARMACY	420		420	168,364		15
16 MEDICAL RECORDS & LIBRARY	3,291		3,291	274,417		16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	6,108		6,108	1,224,568		30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,067		4,067	334,771		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	3,004		3,004	379,165		54
60 LABORATORY	1,198		1,198	466,637		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	336		336	218,531		65
66 PHYSICAL THERAPY		3,907		340,514		66
69 ELECTROCARDIOLOGY	336		336	62,355		69
70 ELECTROENCEPHALOGRAPHY	335		335	13,658		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582		2,582			76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		10,868		2,021,996		88
90 CLINIC						90
91 EMERGENCY	2,795		2,795	729,571		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,244		1,244	454,858		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	51,498	14,775	51,498	8,567,494	-3,249,097	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	269		269			190
192 PHYSICIANS' PRIVATE OFFICES	1,320	906	1,320	32,323		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	690,937	183,793	968,883	3,357,937		202
203 UNIT COST MULT-WS B PT I	13.015183	11.720745	18.250852	0.390466		203
204 COST TO BE ALLOC PER B PT II						204
205 UNIT COST MULT-WS B PT II						205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	RHC UTILITY EXPENSE SQUARE FEET	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	
	5	7	7.01	8	9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	16,337,855					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	555,817	29,519				7
7.01 RHC UTILITY EXPENSE	33,798		15,681			7.01
8 LAUNDRY & LINEN SERVICE	72,981			3,119		8
9 HOUSEKEEPING	343,127	292			29,227	9
10 DIETARY	161,149	1,235			1,235	10
11 CAFETERIA	202,034					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	606,191				251	13
14 CENTRAL SERVICES & SUPPLY	62,396	436			436	14
15 PHARMACY	293,201	420			420	15
16 MEDICAL RECORDS & LIBRARY	516,725	3,291			3,291	16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	1,937,640	6,108		3,119	6,108	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	729,134	4,067			4,067	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,255,675	3,004			3,004	54
60 LABORATORY	1,579,107	1,198			1,198	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	346,448	336			336	65
66 PHYSICAL THERAPY	544,763		3,907			66
69 ELECTROCARDIOLOGY	82,596	336			336	69
70 ELECTROENCEPHALOGRAPHY	29,842	335			335	70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	320,555					71
72 IMPL. DEV. CHARGED TO PATIENT	16,059					72
73 DRUGS CHARGED TO PATIENTS	526,060					73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	546,216	2,582			2,582	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	3,086,697		10,868			88
90 CLINIC	27,446					90
91 EMERGENCY	1,573,204	2,795			2,795	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	768,876	1,244			1,244	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	16,217,737	27,930	14,775	3,119	27,638	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8,410	269			269	190
192 PHYSICIANS' PRIVATE OFFICES	111,708	1,320	906		1,320	192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	3,249,097	666,352	40,519	87,495	417,956	202
203 UNIT COST MULT-WS B PT I	0.198869	22.573664	2.583955	28.052260	14.300339	203
204 COST TO BE ALLOC PER B PT II	724,341	37,180	1,498	3,236	24,710	204
205 UNIT COST MULT-WS B PT II	0.044335	1.259528	0.095530	1.037512	0.845451	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
	PATIENT DAYS	GROSS SALARIES	DIRECT NRSING HRS	COSTED REQUIS.	COSTED REQUIS.	
	10	11	13	14	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
1.01 NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2 CAP REL COSTS-MVBLE EQUIP.						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
7.01 RHC UTILITY EXPENSE						7.01
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	3,119					10
11 CAFETERIA		7,153,501				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		406,843	3,900,884			13
14 CENTRAL SERVICES & SUPPLY		24,930	24,930	938,767		14
15 PHARMACY		168,364	168,364	9,502	475,241	15
16 MEDICAL RECORDS & LIBRARY		274,417				16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,119	1,224,568	1,071,195	16,058		30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		334,771	334,771	248,391		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		379,165	379,165	59,217		54
60 LABORATORY		466,637	466,637	466,927		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		218,531	271,393	9,797		65
66 PHYSICAL THERAPY		340,514		4,676		66
69 ELECTROCARDIOLOGY		62,355		109		69
70 ELECTROENCEPHALOGRAPHY		13,658		69		70
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				67,829		71
72 IMPL. DEV. CHARGED TO PATIENT				16,059		72
73 DRUGS CHARGED TO PATIENTS					475,241	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVICES						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		2,021,996		10,332		88
90 CLINIC						90
91 EMERGENCY		729,571	729,571	26,728		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		454,858	454,858	3,038		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	3,119	7,121,178	3,900,884	938,732	475,241	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES		32,323		35		192
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	238,736	242,212	749,774	96,518	406,036	202
203 UNIT COST MULT-WS B PT I	76.542482	0.033859	0.192206	0.102814	0.854379	203
204 COST TO BE ALLOC PER B PT II	48,359	8,957	35,760	17,576	28,946	204
205 UNIT COST MULT-WS B PT II	15.504649	0.001252	0.009167	0.018722	0.060908	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		16	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT		1.01
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5	ADMINISTRATIVE & GENERAL		5
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
7.01	RHC UTILITY EXPENSE		7.01
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY	43,913,127	16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	2,394,022	30
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	2,071,530	50
53	ANESTHESIOLOGY		53
54	RADIOLOGY-DIAGNOSTIC	9,632,840	54
60	LABORATORY	9,003,648	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	493,905	65
66	PHYSICAL THERAPY	1,814,701	66
69	ELECTROCARDIOLOGY	602,611	69
70	ELECTROENCEPHALOGRAPHY	336,398	70
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	2,801,956	71
72	IMPL. DEV. CHARGED TO PATIENT	92,750	72
73	DRUGS CHARGED TO PATIENTS	5,582,477	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	950,156	76
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
88	RURAL HEALTH CLINIC (RHC)	2,457,910	88
90	CLINIC	82,741	90
91	EMERGENCY	4,222,996	91
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
95	AMBULANCE SERVICES	1,372,486	95
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	43,913,127	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		190
192	PHYSICIANS' PRIVATE OFFICES		192
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	COST TO BE ALLOC PER B PT I	750,129	202
203	UNIT COST MULT-WS B PT I	0.017082	203
204	COST TO BE ALLOC PER B PT II	133,077	204
205	UNIT COST MULT-WS B PT II	0.003030	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS	3,164,337		3,164,337		30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1,160,706		1,160,706		50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	1,872,516		1,872,516		54
60 LABORATORY	2,244,614		2,244,614		60
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
65 RESPIRATORY THERAPY	496,742		496,742		65
66 PHYSICAL THERAPY	706,204		706,204		66
69 ELECTROCARDIOLOGY	123,828		123,828		69
70 ELECTROENCEPHALOGRAPHY	54,345		54,345		70
71 MEDICAL SUPPLIES CHRGD TO	439,140		439,140		71
72 IMPL. DEV. CHARGED TO PATIE	22,488		22,488		72
73 DRUGS CHARGED TO PATIENTS	1,132,073		1,132,073		73
76 PSYCHIATRIC/PSYCHOLOGICAL S	766,280		766,280		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	3,840,144		3,840,144		88
90 CLINIC	34,317		34,317		90
91 EMERGENCY	2,228,944		2,228,944		91
92 OBSERVATION BEDS	74,494		74,494		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	1,094,238		1,094,238		95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THE					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	19,455,410		19,455,410		200
201 LESS OBSERVATION BEDS	74,494		74,494		201
202 TOTAL (SEE INSTRUCTIONS)	19,380,916		19,380,916		202

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 (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						30
ADULTS & PEDIATRICS	2,208,715		2,208,715			
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	371,395	1,700,135	2,071,530	0.560313		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	797,958	8,834,882	9,632,840	0.194389		54
60 LABORATORY	1,602,102	7,401,546	9,003,648	0.249301		60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	365,939	127,966	493,905	1.005744		65
66 PHYSICAL THERAPY	191,182	1,623,519	1,814,701	0.389157		66
69 ELECTROCARDIOLOGY	42,239	560,372	602,611	0.205486		69
70 ELECTROENCEPHALOGRAPHY	4,325	332,073	336,398	0.161550		70
71 MEDICAL SUPPLIES CHRGD TO	1,428,718	1,373,238	2,801,956	0.156726		71
72 IMPL. DEV. CHARGED TO PATIE	22,943	69,807	92,750	0.242458		72
73 DRUGS CHARGED TO PATIENTS	2,603,150	2,979,327	5,582,477	0.202790		73
76 PSYCHIATRIC/PSYCHOLOGICAL S		950,156	950,156	0.806478		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		2,457,910	2,457,910			88
90 CLINIC		82,741	82,741	0.414752		90
91 EMERGENCY	134,769	4,088,227	4,222,996	0.527811		91
92 OBSERVATION BEDS	400	184,907	185,307	0.402003		92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		1,372,486	1,372,486	0.797267		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	9,773,835	34,139,292	43,913,127			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		34,139,292	43,913,127			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1351) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS		PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4					
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.560313		787,977				441,514		50
53 ANESTHESIOLOGY									53
54 RADIOLOGY-DIAGNOSTIC	0.194389		3,485,156				677,476		54
60 LABORATORY	0.249301		3,654,039				910,956		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65 RESPIRATORY THERAPY	1.005744		53,671				53,979		65
66 PHYSICAL THERAPY	0.389157		560,319				218,052		66
69 ELECTROCARDIOLOGY	0.205486		285,470				58,660		69
70 ELECTROENCEPHALOGRAPHY	0.161550		115,483				18,656		70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.156726		448,638				70,313		71
72 IMPL. DEV. CHARGED TO PATIENT	0.242458		56,437				13,684		72
73 DRUGS CHARGED TO PATIENTS	0.202790		1,440,414				292,102		73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.806478		948,282				764,769		76
76.97 CARDIAC REHABILITATION									76.97
76.98 HYPERBARIC OXYGEN THERAPY									76.98
76.99 LITHOTRIPSY									76.99
OUTPATIENT SERVICE COST CENTERS									
88 RURAL HEALTH CLINIC (RHC)									88
90 CLINIC	0.414752		35,775				14,838		90
91 EMERGENCY	0.527811		1,321,687				697,601		91
92 OBSERVATION BEDS	0.402003		56,233				22,606		92
OTHER REIMBURSABLE COST CENTERS									
95 AMBULANCE SERVICES	0.797267								95
200 SUBTOTAL (SEE INSTRUCTIONS)			13,249,581				4,255,206		200
201 LESS PBP CLINIC LAB SERVICES									201
202 NET CHARGES (LINE 200 - LINE 201)			13,249,581				4,255,206		202

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2012 TO 02/28/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 07/15/2013 16:26

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-2351)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES		PROGRAM COSTS	
		PPS REIMBURSED SERVICES 2	COST REIMB. SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES SUBJECT TO DED & COINS 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.560313				50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	0.194389				54
60 LABORATORY	0.249301				60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	1.005744				65
66 PHYSICAL THERAPY	0.389157				66
69 ELECTROCARDIOLOGY	0.205486				69
70 ELECTROENCEPHALOGRAPHY	0.161550				70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.156726				71
72 IMPL. DEV. CHARGED TO PATIENT	0.242458				72
73 DRUGS CHARGED TO PATIENTS	0.202790				73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.806478				76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
90 CLINIC	0.414752				90
91 EMERGENCY	0.527811				91
92 OBSERVATION BEDS	0.402003				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	0.797267				95
200 SUBTOTAL (SEE INSTRUCTIONS)					200
201 LESS PBP CLINIC LAB SERVICES					201
202 NET CHARGES (LINE 200 - LINE 201)					202

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1351) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,823	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,209	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,119	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	512	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	102	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,163	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	512	10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	102	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	118.00	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	118.00	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,164,337	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	508,214	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,656,123	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,208,715	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,208,715	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.202565	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	708.15	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,656,123	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1351) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 827.71 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,790,337 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,790,337 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42

43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						43
44 INTENSIVE CARE UNIT						44
45 CORONARY CARE UNIT						45
46 BURN INTENSIVE CARE UNIT						46
47 SURGICAL INTENSIVE CARE UNIT						47
48 OTHER SPECIAL CARE (SPECIFY)						48
49 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					1,196,610	49
TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,986,947	49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51
 52 TOTAL PROGRAM EXCLUDABLE COST 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION
 54 PROGRAM DISCHARGES 54
 55 TARGET AMOUNT PER DISCHARGE 55
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

64 PROGRAM INPATIENT ROUTINE SWING BED COST						
MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					423,788	64
65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)					84,426	65
66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)					508,214	66
67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19)						67
68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20)						68
69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68)						69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 90 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 827.71 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 74,494 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	360,237	2,656,123	0.135625	74,494	10,103	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2012 TO 02/28/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 07/15/2013 16:26

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1351) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		1,462,164		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.560313	287,534	161,109	50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.194389	403,164	78,371	54
60 LABORATORY	0.249301	989,736	246,742	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	1.005744	222,361	223,638	65
66 PHYSICAL THERAPY	0.389157	97,001	37,749	66
69 ELECTROCARDIOLOGY	0.205486	35,934	7,384	69
70 ELECTROENCEPHALOGRAPHY	0.161550	730	118	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.156726	875,464	137,208	71
72 IMPL. DEV. CHARGED TO PATIENT	0.242458	13,793	3,344	72
73 DRUGS CHARGED TO PATIENTS	0.202790	1,481,267	300,386	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.806478			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.414752			90
91 EMERGENCY	0.527811	993	524	91
92 OBSERVATION BEDS	0.402003	91	37	92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,408,068	1,196,610	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,408,068		202

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM VERSION: 2012.11
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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z351) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
30 INPATIENT ROUTINE SERVICE COST CENTERS				30
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.560313			50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.194389	37,207	7,233	54
60 LABORATORY	0.249301	167,720	41,813	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	1.005744	65,313	65,688	65
66 PHYSICAL THERAPY	0.389157	80,377	31,279	66
69 ELECTROCARDIOLOGY	0.205486	3,369	692	69
70 ELECTROENCEPHALOGRAPHY	0.161550	726	117	70
71 MEDICAL SUPPLIES CHRGD TO PATI	0.156726	200,098	31,361	71
72 IMPL. DEV. CHARGED TO PATIENT	0.242458			72
73 DRUGS CHARGED TO PATIENTS	0.202790	330,076	66,936	73
76 PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.806478			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.414752			90
91 EMERGENCY	0.527811			91
92 OBSERVATION BEDS	0.402003	270	109	92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		885,156	245,228	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		885,156		202

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM VERSION: 2012.11
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[XX] HOSPITAL (14-1351) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] SWING BED SNF	INPATIENT		PART B		
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			2,557,412		2,993,094	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.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99	08/29/2012 11/05/2012 02/19/2013	31,646 11,439 23,435	09/13/2012	14,823	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
	SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)			66,520		-191,134	3.99
4	TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)			2,623,932		2,801,960	4
TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99					5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
	SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						5.99
6	DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	.01 .02					6.01 6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)						7
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL	[] SUB (OTHER)	INPATIENT PART A	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	[] IPF	[] SNF	PART B	1	2	3	4
	[] IRF	[XX] SWING BED SNF (14-Z351)					
DESCRIPTION							
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER					612,932		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 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.							
		.01			NONE		3.01
		.02					3.02
		PROGRAM .03					3.03
		TO .04					3.04
		PROVIDER .05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.50	08/29/2012		10,088		NONE 3.50
		.51					3.51
		PROVIDER .52					3.52
		TO .53					3.53
		PROGRAM .54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		.99			-10,088		3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)					602,844		4
TO BE COMPLETED BY CONTRACTOR							
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
		.04					5.04
		.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		PROVIDER .50					5.50
		TO .51					5.51
		PROGRAM .52					5.52
		.53					5.53
		.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		.99					5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT							
		PROGRAM .01					6.01
		TO .02					6.02
		PROVIDER .01					6.01
		TO .02					6.02
		PROGRAM .01					6.01
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							7
8 NAME OF CONTRACTOR:					CONTRACTOR NUMBER:	NPR DATE:	8

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1351) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	950	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,163	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,119	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	43,913,127	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	792,673	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-2351)
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	513,296	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	247,680	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	614	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	760,976	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	760,976	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	760,976	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	8,395	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	752,581	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	752,581	19
20 INTERIM PAYMENTS	602,844	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	149,737	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART V

CHECK [XX] HOSPITAL (14-1351)
 APPLICABLE BOX: [] SUB (OTHER)

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

1	INPATIENT SERVICES	2,986,947	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,986,947	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	3,016,816	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	3,016,816	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	388,160	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	2,628,656	22
23	COINSURANCE	5,173	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	2,623,483	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)		25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	103,848	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	103,848	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	2,727,331	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	2,727,331	30
31	INTERIM PAYMENTS	2,623,932	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	103,399	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

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	2,296,983			1
2	TEMPORARY INVESTMENTS	2,957,582			2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	4,391,590			4
5	OTHER RECEIVABLES	516,041			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7	INVENTORY	160,467			7
8	PREPAID EXPENSES	206,556			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	10,529,219			11
FIXED ASSETS					
12	LAND	132,111			12
13	LAND IMPROVEMENTS	345,852			13
14	ACCUMULATED DEPRECIATION	-261,745			14
15	BUILDINGS	12,494,205			15
16	ACCUMULATED DEPRECIATION	-7,442,898			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	7,772,791			19
20	ACCUMULATED DEPRECIATION	-5,861,483			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT				23
24	ACCUMULATED DEPRECIATION				24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	7,178,833			30
OTHER ASSETS					
31	INVESTMENTS				31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	4,576,716			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	4,576,716			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	22,284,768			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	1,120,210			37
38	SALARIES, WAGES & FEES PAYABLE	632,987			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)				40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	310,958			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,064,155			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	4,376,892			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	4,376,892			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	6,441,047			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	15,843,721			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	15,843,721			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	22,284,768			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		15,342,189							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		501,532							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		15,843,721							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		15,843,721							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		15,843,721							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	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	2,388,809		2,388,809	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,388,809		2,388,809	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,388,809		2,388,809	17
18 ANCILLARY SERVICES	7,829,143		7,829,143	18
19 OUTPATIENT SERVICES		33,256,243	33,256,243	19
20 RHC		2,877,719	2,877,719	20
20.01 RHC II				20.01
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE		1,372,486	1,372,486	23
25 ASC				25
26 HOSPICE				26
27 OTHER (SPECIFY)				27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	10,217,952	37,506,448	47,724,400	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		21,354,828	29
30 PROVISION FOR BAD DEBTS	2,750,981		30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)		2,750,981	36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		24,105,809	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	47,724,400	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	24,279,286	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	23,445,114	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	24,105,809	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-660,695	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	140,239	6
7	INCOME FROM INVESTMENTS	70,235	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	109,000	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE 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	6,108	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	OTHER (TAX REVENUE)	204,016	24
24.01	OTHER (RENTAL INCOME)	54,614	24.01
24.02	OTHER (MISCELLANEOUS INCOME)	22,090	24.02
24.03	OTHER (GRANT INCOME)	325,000	24.03
24.04	OTHER (EHR INCENTIVE)	230,925	24.04
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,162,227	25
26	TOTAL (LINE 5 PLUS LINE 25)	501,532	26
27			27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	501,532	29

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

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-1

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	1,011,358		1,011,358		1,011,358	-59,792	951,566	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	174,899		174,899		174,899		174,899	3
4 VISITING NURSE								4
5 OTHER NURSE	479,708		479,708		479,708		479,708	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	3,988		3,988		3,988		3,988	9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	1,669,953		1,669,953		1,669,953	-59,792	1,610,161	10
11 PHYSICIAN SERVICES UNDER AGREEMENT		57,933	57,933		57,933		57,933	11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS		57,933	57,933		57,933		57,933	14
15 MEDICAL SUPPLIES		39,827	39,827		39,827		39,827	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		21,849	21,849		21,849		21,849	18
19 OTHER HEALTH CARE COSTS		87,982	87,982		87,982		87,982	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		149,658	149,658		149,658		149,658	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21) COSTS OTHER THAN RHC/FQHC SERVICES	1,669,953	207,591	1,877,544		1,877,544	-59,792	1,817,752	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 (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS	352,043		352,043		352,043		352,043	29
30 ADMINISTRATIVE COSTS								30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	352,043		352,043		352,043		352,043	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	2,021,996	207,591	2,229,587		2,229,587	-59,792	2,169,795	32

PROVIDER CCN: 14-1351 CLAY COUNTY HOSPITAL
 PERIOD FROM 03/01/2012 TO 02/28/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2012.11
 07/15/2013 16:26

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	2.56	12,085	4,200	10,752	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	2.60	11,144	2,100	5,460	3
4	SUBTOTAL (SUM OF LINES 1-3)	5.16	23,229		16,212	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5.16	23,229			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		11			11 9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,817,752	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,817,752	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				352,043	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,670,349	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				2,022,392	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				2,022,392	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				2,022,392	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				3,840,144	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	3,840,144	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	11,941	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	3,828,203	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	23,229	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)	11	5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	23,240	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	164.72	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	164.72	164.72	164.72 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	6,543	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	1,077,763	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	1,077,763	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	799,420	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	799,420	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	78,488	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	799,420	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	17,196	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	816,616	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	36,994	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	36,994	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	853,610	26
27	INTERIM PAYMENTS	726,127	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	127,483	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		30

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
 COMPONENT NO: 14-3458

WORKSHEET M-4

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,610,161	1,610,161	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000081	0.000848	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	130	1,365	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	756	3,402	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	886	4,767	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,817,752	1,817,752	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	2,022,392	2,022,392	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000487	0.002622	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	985	5,303	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,871	10,070	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	12	126	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	155.92	79.92	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	17	182	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	2,651	14,545	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		11,941	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		17,196	16

