

CLAY COUNTY HOSPITAL
FLORA, ILLINOIS
MEDICARE COST REPORT
YEAR ENDED FEBRUARY 28, 2014

Optimizer Systems, Inc.

WinLASH

Micro System

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2013 To: 02/28/2014	Run Date: 07/22/2014 Run Time: 13:17 Version: 2014.03
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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. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 07/22/2014	TIME: 13:17
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> 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. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	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 WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 03/01/2013 AND ENDING 02/28/2014, 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: 07/22/2014 13:17
H1K34A1rqveWPghctftlku0KetUjmD
FY2.t0bBIK3mps2OGTPXdvh.51Y0gD
bpSp0FUIEH0zxiSU

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

TITLE

DATE

PI Encryption: 07/22/2014 13:17
XWh22unmmMJZe0iyEVBiCKNO00s2a80
A4Ga:0MTyKQ1eeJahiU6Ds2wnNfr:Y
AvpP09.f280NV2Cu

PART III - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		HIF	TITLE XIX	
		PART A	PART B			
	1	2	3	4	5	
1 HOSPITAL		66,278	111,097		220,666	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		4,220				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			-8,577			10
10.01 HEALTH CLINIC - RHC II						10.01
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		70,498	102,520		220,666	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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:											
1	Street: 911 STACY BURK DRIVE	P.O. Box:							1		
2	City: FLORA	State: IL	ZIP Code: 62839-0280	County: CLAY						2	
Hospital and Hospital-Based Component Identification:											
										Payment System (P, T, O, or N)	
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX		
	0	1	2	3	4	5	6	7	8		
3	Hospital	CLAY COUNTY HOSPITAL	14-1351	99914	1	12/21/2005	N	O	O	3	
4	Subprovider - IPF									4	
5	Subprovider - IRF									5	
6	Subprovider - (OTHER)									6	
7	Swing Beds - SNF	CLAY COUNTY SWING BED	14-Z351	99914		12/21/2005	N	O	N	7	
8	Swing Beds - NF									8	
9	Hospital-Based SNF									9	
10	Hospital-Based NF									10	
11	Hospital-Based OLTG									11	
12	Hospital-Based HHA									12	
13	Separately Certified ASC									13	
14	Hospital-Based Hospice									14	
15	Hospital-Based Health Clinic - RHC	CLAY COUNTY MEDICAL CLINIC	14-3458	99914		11/29/2005	N	O	N	15	
15.01	Hospital-Based Health Clinic - RHC II	LOUISVILLE MEDICAL CLINIC	14-3487	99914		12/18/2006	N	O	N	15.01	
16	Hospital-Based Health Clinic - FQHC									16	
17	Hospital-Based (CMHC)									17	
18	Renal Dialysis									18	
19	Other									19	
20	Cost Reporting Period (mm/dd/yyyy)	From: 03 / 01 / 2013	To: 02 / 28 / 2014								20
21	Type of control (see instructions)	9									21
Inpatient PPS Information										1 2	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.							N	N	22	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							N	N	22.01	
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.							3	N	23	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days				
		1	2	3	4	5	6				
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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.									24	
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.									25	
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.				2					26	
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2					27	
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								35		
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				Beginning:	Ending:					
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.								37		
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:	Ending:					
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)							1	2	39	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete 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
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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

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WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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 5th or 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.						86

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WORKSHEET S-2
PART I

		V	XIX				
Title V and XIX Services		1	2				
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90			
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91			
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92			
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93			
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94			
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95			
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96			
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97			
Rural Providers		1	2				
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105			
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106			
107	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 25 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.	N	N	N	Speech	Respiratory	109
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'	N		115			
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116			
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y		117			
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118			
		Premiums	Paid Losses	Self Insurance			
118.01	List amounts of malpractice premiums and paid losses:	67,000			118.01		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02		
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N		120		
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121		
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		

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WORKSHEET S-2
PART I

All Providers		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on 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.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	Y		149
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)				
		Title XVIII		
		Part A	Part B	Title V
			1	2
				3
155	Hospital	N	N	N
156	Subprovider - IPF	N	N	
157	Subprovider - IRF	N	N	
158	Subprovider - Other			
159	SNF	N	N	
160	HHA	N	N	
161	CMHC		N	
161.10	CORF			
Multicampus				
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N		165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.			166
	Name	County	State	ZIP Code
	0	1	2	3
				CBSA
				FTE/Campus
				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 is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)			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. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
		1	2	3	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N	
		1		2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR 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
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
PS&R REPORT DATA		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	04/22/2014	Y	04/22/2014
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	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART IIGENERAL 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 COSTS			
22	HAVE ASSETS BEEN RELIEVED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	N	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S 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.	N	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
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
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	
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	N	
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
COST REORT PREPARER INFORMATION			
41	FIRST NAME: MARK	LAST NAME: W	TITLE: DALLAS
42	EMPLOYER: KERBER, ECK, & BRAECKEL		
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: MARKD@KEBCPA.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	18	6,570	157,680.00		2,165	283	2,918	1
2	HMO AND OTHER (see instructions)									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						679		679	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		18	6,570	157,680.00		2,844	283	3,597	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)		18	6,570	157,680.00		2,844	283	3,597	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					7,143		24,873	26
26.01	RHC II	88.01								26.01
27	TOTAL (sum of lines 14-26)		18							27
28	OBSERVATION BED DAYS							24	135	28
29	AMBULANCE TRIPS						931			29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					512	96	755	1
2	HMO AND OTHER (see instructions)								2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		156.40			512	96	755	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC		30.00						26
26.01	RHC II								26.01
27	TOTAL (sum of lines 14-26)		186.40						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

		WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
		1	2	3	4	5	6	
SALARIES								
1	TOTAL SALARIES (see instructions)	200						1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN-PART A - ADMINISTRATIVE							4
4.01	PHYSICIAN-PART A - TEACHING							4.01
5	PHYSICIAN-PART B							5
6	NON-PHYSICIAN-PART B							6
7	INTERNS & RESIDENTS (in an approved program)	21						7
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)							7.01
8	HOME OFFICE PERSONNEL							8
9	SNF	44						9
10	EXCLUDED AREA SALARIES (see instructions)							10
OTHER WAGES & RELATED COSTS								
11	CONTRACT LABOR (see instructions)							11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES							12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE							13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS							14
15	HOME OFFICE: PHYSICIAN PART A - ADMINISTRATIVE							15
16	HOME OFFICE & CONTRACT PHYSICIANS PART A - TEACHING							16
WAGE-RELATED COSTS								
17	WAGE-RELATED COSTS (core)(see instructions)							17
18	WAGE-RELATED COSTS (other)(see instructions)							18
19	EXCLUDED AREAS							19
20	NON-PHYSICIAN ANESTHETIST PART A							20
21	NON-PHYSICIAN ANESTHETIST PART B							21
22	PHYSICIAN PART A - ADMINISTRATIVE							22
22.01	PHYSICIAN PART A - TEACHING							22.01
23	PHYSICIAN PART B							23
24	WAGE-RELATED COSTS (RHC/FQHC)							24
25	INTERNS & RESIDENTS (in an approved program)							25
OVERHEAD COSTS - DIRECT SALARIES								
26	EMPLOYEE BENEFITS DEPARTMENT							26
27	ADMINISTRATIVE & GENERAL							27
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)							28
29	MAINTENANCE & REPAIRS							29
30	OPERATION OF PLANT							30
31	LAUNDRY & LINEN SERVICE							31
32	HOUSEKEEPING							32
33	HOUSEKEEPING UNDER CONTRACT (see instructions)							33
34	DIETARY							34
35	DIETARY UNDER CONTRACT (see instructions)							35
36	CAFETERIA							36
37	MAINTENANCE OF PERSONNEL							37
38	NURSING ADMINISTRATION							38
39	CENTRAL SERVICES AND SUPPLY							39
40	PHARMACY							40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY							41
42	SOCIAL SERVICE							42
43	OTHER GENERAL SERVICE							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 instructions)							4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)							5
6	TOTAL (sum of lines 3 through 5)							6
7	TOTAL OVERHEAD COST (see instructions)							7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

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 employee 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 REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIBUTION(S)
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

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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 1	BENEFIT COST 2	
	0			
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 OLTC			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

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Micro System

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

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

SNF SERVICES

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

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH 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	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)				207

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

COMPONENT CCN: 14-3458

WORKSHEET S-8

CHECK [XX] RHC [] FQHC
APPLICABLE BOX:

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 929 STACY BURK DRIVE	1
2	CITY: FLORA STATE: IL ZIP CODE: 62839 COUNTY: CLAY	2
3	FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN	3

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER			9

		1	2	
10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	CLINIC			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	Y	2	13
14	PROVIDER NAME: CLAY COUNTY HOSPITAL CLIN CCN NUMBER: 14-3458			14
14.01	PROVIDER NAME: LOUISVILLE MEDICAL CLINIC CCN NUMBER: 14-3487			14.01

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.432897	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	3,051,416	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	8,889,284	6
7	MEDICAID COST (line 1 times line 6)	3,848,144	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.	796,728	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 AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		136,432	17	
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		298,489	18	
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		796,728	19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	744,345	350,261	1,094,606	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	322,225	151,627	473,852	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	244,581	303,835	548,416	22
23	COST OF CHARITY CARE (line 21 minus line 22)	77,644	-152,208	-74,564	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)	3,797,590	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	630,691	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	3,166,899	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	1,370,941	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,296,377	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	2,093,105	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		922,775	922,775	-180,654	742,121	-23,613	718,508	1
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT		2,728	2,728	175,279	178,007		178,007	1.01
2	00200	CAP REL COSTS-MVBLE EQUIP		963,801	963,801	5,375	969,176		969,176	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	100,056	3,245,143	3,345,199		3,345,199	-94,080	3,251,119	4
5	00500	ADMINISTRATIVE & GENERAL	918,340	1,707,978	2,626,318	-84,000	2,542,318	-190,849	2,351,469	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	157,543	373,230	530,773		530,773		530,773	7
7.01	00701	RHC UTILITY EXPENSE		36,580	36,580		36,580		36,580	7.01
8	00800	LAUNDRY & LINEN SERVICE		77,318	77,318		77,318		77,318	8
9	00900	HOUSEKEEPING	206,842	51,377	258,219		258,219		258,219	9
10	01000	DIETARY	196,154	168,954	365,108	-262,878	102,230		102,230	10
11	01100	CAFETERIA				262,878	262,878	-115,150	147,728	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	438,387	33,761	472,148	76,302	548,450		548,450	13
14	01400	CENTRAL SERVICES & SUPPLY	24,391	9,275	33,666		33,666		33,666	14
15	01500	PHARMACY	172,075	76,073	248,148		248,148		248,148	15
16	01600	MEDICAL RECORDS & LIBRARY	269,741	117,742	387,483		387,483	-7,253	380,230	16
17	01700	SOCIAL SERVICE								17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		INPATIENT ROUTINE SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,242,827	60,171	1,302,998		1,302,998	-235,159	1,067,839	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	426,306	124,406	550,712	6,755	557,467		557,467	50
53	05300	ANESTHESIOLOGY		231,527	231,527	-6,755	224,772	-224,772		53
54	05400	RADIOLOGY-DIAGNOSTIC	399,096	628,994	1,028,090		1,028,090		1,028,090	54
60	06000	LABORATORY	481,958	913,478	1,395,436		1,395,436		1,395,436	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	275,060	40,806	315,866	-55,012	260,854	-2,139	258,715	65
66	06600	PHYSICAL THERAPY	342,548	36,909	379,457		379,457		379,457	66
69	06900	ELECTROCARDIOLOGY	26,220	1,340	27,560	41,259	68,819	-20,490	48,329	69
70	07000	ELECTROENCEPHALOGRAPHY		58,860	58,860	13,753	72,613	-58,550	14,063	70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		310,189	310,189	-24,456	285,733	-898	284,835	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				24,456	24,456		24,456	72
73	07300	DRUGS CHARGED TO PATIENTS		436,262	436,262		436,262		436,262	73
76	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		492,528	492,528		492,528		492,528	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	RURAL HEALTH CLINIC	2,177,604	238,827	2,416,431		2,416,431	-228,691	2,187,740	88
90	09000	CLINIC		18,300	18,300	7,698	25,998		25,998	90
91	09100	EMERGENCY	817,472	1,633,236	2,450,708		2,450,708	-850,170	1,600,538	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	AMBULANCE SERVICES	487,489	110,106	597,595		597,595		597,595	95
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	9,160,109	13,122,674	22,282,783		22,282,783	-2,051,814	20,230,969	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES	28,960	11,561	40,521		40,521		40,521	192
200		TOTAL (sum of lines 118-199)	9,189,069	13,134,235	22,323,304		22,323,304	-2,051,814	20,271,490	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	DEPRICIATION	A	NEW CAP RHC REL COSTS-BLDG &	1.01		169,750	1
500	TOTAL RECLASSIFICATIONS					169,750	500
	CODE LETTER - A						
1	RESPIRATORY THERAPY	B	ELECTROCARDIOLOGY	69	41,259		1
2			ELECTROENCEPHALOGRAPHY	70	13,753		2
500	TOTAL RECLASSIFICATIONS				55,012		500
	CODE LETTER - B						
1	INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	1.01		5,529	1
2			CAP REL COSTS-MVBLE EQUIP	2		5,375	2
500	TOTAL RECLASSIFICATIONS					10,904	500
	CODE LETTER - C						
1	OPERATING ROOM	D	OPERATING ROOM	50		6,755	1
500	TOTAL RECLASSIFICATIONS					6,755	500
	CODE LETTER - D						
1	RECLASS PORTION OF DIETARY TO CAFE	E	CAFETERIA	11	141,231	121,647	1
500	TOTAL RECLASSIFICATIONS				141,231	121,647	500
	CODE LETTER - E						
1	RECLASS IMPLANTABLE DEVICE COST	F	IMPL. DEV. CHARGED TO PATIENT	72		24,456	1
500	TOTAL RECLASSIFICATIONS					24,456	500
	CODE LETTER - F						
1	DIEBETIES EDUCATION	G	CLINIC	90	6,807	891	1
500	TOTAL RECLASSIFICATIONS				6,807	891	500
	CODE LETTER - G						
1	CNE SALARY EXPENSE	H	NURSING ADMINISTRATION	13	84,000		1
500	TOTAL RECLASSIFICATIONS				84,000		500
	CODE LETTER - H						
	GRAND TOTAL (INCREASES)				287,050	334,403	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	DEPRICIATION	A	CAP REL COSTS-BLDG & FIXT	1		169,750	9	1
500	TOTAL RECLASSIFICATIONS					169,750		500
	CODE LETTER - A							
1	RESPIRATORY THERAPY	B	RESPIRATORY THERAPY	65	55,012			1
2								2
500	TOTAL RECLASSIFICATIONS				55,012			500
	CODE LETTER - B							
1	INSURANCE EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		10,904	12	1
2							12	2
500	TOTAL RECLASSIFICATIONS					10,904		500
	CODE LETTER - C							
1	OPERATING ROOM	D	ANESTHESIOLOGY	53		6,755		1
500	TOTAL RECLASSIFICATIONS					6,755		500
	CODE LETTER - D							
1	RECLASS PORTION OF DIETARY TO CAFE	E	DIETARY	10	141,231	121,647		1
500	TOTAL RECLASSIFICATIONS				141,231	121,647		500
	CODE LETTER - E							
1	RECLASS IMPLANTABLE DEVICE COST	F	MEDICAL SUPPLIES CHARGED TO P	71		24,456		1
500	TOTAL RECLASSIFICATIONS					24,456		500
	CODE LETTER - F							
1	DIEBETIES EDUCATION	G	NURSING ADMINISTRATION	13	6,807	891		1
500	TOTAL RECLASSIFICATIONS				6,807	891		500
	CODE LETTER - G							
1	CNE SALARY EXPENSE	H	ADMINISTRATIVE & GENERAL	5	84,000			1
500	TOTAL RECLASSIFICATIONS				84,000			500
	CODE LETTER - H							
	GRAND TOTAL (DECREASES)				287,050	334,403		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS
			PURCHASES	DONATION	TOTAL			
		1	2	3	4	5	6	7
1	LAND	132,111					132,111	1
2	LAND IMPROVEMENTS	345,852	1,180		1,180		347,032	2
3	BUILDINGS AND FIXTURES	12,494,205	60,645		60,645		12,554,850	3
4	BUILDING IMPROVEMENTS							4
5	FIXED EQUIPMENT							5
6	MOVABLE EQUIPMENT	7,772,793	1,124,420		1,124,420		8,897,213	6
7	HIT DESIGNATED ASSETS							7
8	SUBTOTAL (sum of lines 1-7)	20,744,961	1,186,245		1,186,245		21,931,206	8
9	RECONCILING ITEMS							9
10	TOTAL (line 7 minus line 9)	20,744,961	1,186,245		1,186,245		21,931,206	10

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

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)	TOTAL(1) (Sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	637,000		248,858	36,917			922,775	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT					2,728		2,728	1.01
2	CAP REL COSTS-MVBLE EQUIP	848,714	115,087					963,801	2
3	TOTAL (sum of lines 1-2)	1,485,714	115,087	248,858	36,917	2,728		1,889,304	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	13,033,993		13,033,993	0.594313					1
1.01	NEW CAP RHC REL COSTS-B				0.000000					1.01
2	CAP REL COSTS-MVBLE EQU	8,897,213		8,897,213	0.405687					2
3	TOTAL (sum of lines 1-2)	21,931,206		21,931,206	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)	TOTAL(2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	467,250		225,245	26,013			718,508	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	169,750			5,529	2,728		178,007	1.01
2	CAP REL COSTS-MVBLE EQUIP	848,714	115,087		5,375			969,176	2
3	TOTAL (sum of lines 1-2)	1,485,714	115,087	225,245	36,917	2,728		1,865,691	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-23,613	CAP REL COSTS-BLDG & FIXT	1	11
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	
3	INVESTMENT INCOME-OTHER (chapter 2)					
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-886	ADMINISTRATIVE & GENERAL	5	
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-3,260	ADMINISTRATIVE & GENERAL	5	
8	TELEVISION AND RADIO SERVICE (chapter 21)					
9	PARKING LOT (chapter 21)					
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,385,988			
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-1,357	ADMINISTRATIVE & GENERAL	5	
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1				
13	LAUNDRY AND LINEN SERVICE					
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-115,150	CAFETERIA	11	
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-898	MEDICAL SUPPLIES CHARGED TO PATIENTS	71	
17	SALE OF DRUGS TO OTHER THAN PATIENTS					
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-7,253	MEDICAL RECORDS & LIBRARY	16	
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					
20	VENDING MACHINES	B	-458	ADMINISTRATIVE & GENERAL	5	
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	
29	PHYSICIANS' ASSISTANT					
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	
32	CAH HIT ADJ FOR DEPRECIATION AND					
33	EKG PHYSICIAN EMPLOYEE BENEFITS	A	-91,038	EMPLOYEE BENEFITS DEPARTMENT	4	
34	MISCELLANEOUS REVENUE	B	-15,180	ADMINISTRATIVE & GENERAL	5	
35	PUBLIC RELATIONS	A	-162,731	ADMINISTRATIVE & GENERAL	5	
36	LOBBYING EXPENSE	A	-6,977	ADMINISTRATIVE & GENERAL	5	
37	CRNA EXPENSE	A	-224,772	ANESTHESIOLOGY	53	
38	EMPLOYEE BENEFITS LAB TESTS	A	-3,042	EMPLOYEE BENEFITS DEPARTMENT	4	
39	RHC PHYSICIAN HOSPITAL INCENTIVES	A	-5,161	RURAL HEALTH CLINIC	88	
40	PHYSICIAN RECRUITMENT	A	-4,050	RURAL HEALTH CLINIC	88	
41						
42						
43						
44						
45						
46						
47						
48						
49						
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,051,814			

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
1	2	3	4	5	6	7	
1						1	
2						2	
3						3	
4						4	
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12						5

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER/ COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	30	ADULTS & PEDIATRICS AGGREGATE	235,159	235,159						1
2	60	LABORATORY AGGREGATE	26,500		26,500					2
3	65	RESPIRATORY THERAPY AGGREGATE	2,139	2,139						3
4	69	ELECTROCARDIOLOGY AGGREGATE	20,490	20,490						4
5	70	ELECTROENCEPHALOGRAP AGGREGATE	58,550	58,550						5
6	88	RURAL HEALTH CLINIC AGGREGATE	219,480	219,480						6
7	91	EMERGENCY AGGREGATE	1,521,149	850,170	670,979					7
200		TOTAL	2,083,467	1,385,988	697,479					200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	30	ADULTS & PEDIATRICS AGGREGATE							235,159	1
2	60	LABORATORY AGGREGATE								2
3	65	RESPIRATORY THERAPY AGGREGATE							2,139	3
4	69	ELECTROCARDIOLOGY AGGREGATE							20,490	4
5	70	ELECTROENCEPHALOGRAP AGGREGATE							58,550	5
6	88	RURAL HEALTH CLINIC AGGREGATE							219,480	6
7	91	EMERGENCY AGGREGATE							850,170	7
200		TOTAL							1,385,988	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IVCHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)						15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)						22
23	TOTAL SALARY EQUIVALENCY (see instructions)						23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)						24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)						28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)						33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)						15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)						22
23	TOTAL SALARY EQUIVALENCY (see instructions)						23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)						24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)						28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)						33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46

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CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2013 To: 02/28/2014	Run Date: 07/15/2014 Run Time: 15:49 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VICHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50 (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)						15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)						22
23	TOTAL SALARY EQUIVALENCY (see instructions)						23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)						24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)						28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)						33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE						7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED						9
10	AHSEA (see instructions)						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)						15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)						22
23	TOTAL SALARY EQUIVALENCY (see instructions)						23

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)						24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)						28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)						33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)						36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)						38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)						39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)						44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VICHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50 (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	NEW RHC BUILDING FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	
		0	1	1.01	2	4	4A	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	718,508	718,508					1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	178,007		178,007				1.01
2	CAP REL COSTS-MVBLE EQUIP	969,176			969,176			2
4	EMPLOYEE BENEFITS DEPARTMENT	3,251,119				3,251,119		4
5	ADMINISTRATIVE & GENERAL	2,351,469	313,554		422,944	298,442	3,386,409	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	530,773	5,427		7,321	56,353	599,874	7
7.01	RHC UTILITY EXPENSE	36,580					36,580	7.01
8	LAUNDRY & LINEN SERVICE	77,318					77,318	8
9	HOUSEKEEPING	258,219	3,952		5,331	73,987	341,489	9
10	DIETARY	102,230	16,715		22,547	19,646	161,138	10
11	CAFETERIA	147,728				50,518	198,246	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	548,450	3,397		4,582	184,422	740,851	13
14	CENTRAL SERVICES & SUPPLY	33,666	5,901		7,960	8,725	56,252	14
15	PHARMACY	248,148	5,685		7,668	61,551	323,052	15
16	MEDICAL RECORDS & LIBRARY	380,230	44,542		60,082	96,486	581,340	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,067,839	82,669		111,510	444,557	1,706,575	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	557,467	55,045		74,249	152,489	839,250	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	1,028,090	40,658		54,842	142,756	1,266,346	54
60	LABORATORY	1,395,436	16,214		21,871	172,395	1,605,916	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	258,715	4,548		6,134	78,711	348,108	65
66	PHYSICAL THERAPY	379,457		43,782		122,529	545,768	66
69	ELECTROCARDIOLOGY	48,329	4,548		6,134	24,137	83,148	69
70	ELECTROENCEPHALOGRAPHY	14,063	4,534		6,116	4,919	29,632	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	284,835					284,835	71
72	IMPL. DEV. CHARGED TO PATIENTS	24,456					24,456	72
73	DRUGS CHARGED TO PATIENTS	436,262					436,262	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	492,528	34,946		47,138		574,612	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	2,187,740		121,786		778,920	3,088,446	88
90	CLINIC	25,998				2,435	28,433	90
91	EMERGENCY	1,600,538	37,829		51,027	292,408	1,981,802	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	597,595	16,837		22,711	174,374	811,517	95
99.10	CORP							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)	20,230,969	697,001	165,568	940,167	3,240,760	20,157,655	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,641		4,911		8,552	190
192	PHYSICIANS' PRIVATE OFFICES	40,521	17,866	12,439	24,098	10,359	105,283	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	20,271,490	718,508	178,007	969,176	3,251,119	20,271,490	202

Optimizer Systems, Inc.

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Micro System

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2013 To: 02/28/2014	Run Date: 07/15/2014 Run Time: 15:49 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	
		5	7	7.01	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL	3,386,409						5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	120,308	720,182					7
7.01	RHC UTILITY EXPENSE		7,336	43,916				7.01
8	LAUNDRY & LINEN SERVICE	15,507			92,825			8
9	HOUSEKEEPING	68,488	7,124			417,101		9
10	DIETARY	32,317	30,131			12,847	236,433	10
11	CAFETERIA	39,759						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	148,582	6,124			2,611		13
14	CENTRAL SERVICES & SUPPLY	11,282	10,637			4,536		14
15	PHARMACY	64,790	10,247			4,369		15
16	MEDICAL RECORDS & LIBRARY	116,591	80,291			34,236		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	342,264	149,019		92,825	63,540	236,433	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	168,317	99,224			42,308		50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	253,973	73,289			31,250		54
60	LABORATORY	322,076	29,228			12,463		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	69,815	8,197			3,495		65
66	PHYSICAL THERAPY	109,457		10,801				66
69	ELECTROCARDIOLOGY	16,676	8,197			3,495		69
70	ELECTROENCEPHALOGRAPHY	5,943	8,173			3,485		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	57,125						71
72	IMPL. DEV. CHARGED TO PATIENTS	4,905						72
73	DRUGS CHARGED TO PATIENTS	87,495						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	115,242	62,994			26,860		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	619,412		30,046		113,059		88
90	CLINIC	5,702						90
91	EMERGENCY	397,462	68,190			29,076		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	162,755	30,350			12,941		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)	3,363,579	681,415	40,847	92,825	400,571	236,433	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,715	6,563			2,798		190
192	PHYSICIANS' PRIVATE OFFICES	21,115	32,204	3,069		13,732		192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,386,409	720,182	43,916	92,825	417,101	236,433	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		11	13	14	15	16	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
7.01	RHC UTILITY EXPENSE							7.01
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA	238,005						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	15,948	914,116					13
14	CENTRAL SERVICES & SUPPLY	754	5,689	89,150				14
15	PHARMACY	5,323		917	408,698			15
16	MEDICAL RECORDS & LIBRARY	8,344				820,802		16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	38,444	235,015	2,175		43,690	2,909,980	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	13,187	99,425	23,821		35,492	1,321,024	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	12,345	93,080	5,240		180,826	1,916,349	54
60	LABORATORY	14,908	112,405	41,312		177,155	2,315,463	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	6,807	64,151	1,056		8,969	510,598	65
66	PHYSICAL THERAPY	10,596		444		35,935	713,001	66
69	ELECTROCARDIOLOGY	2,087		18		11,902	125,523	69
70	ELECTROENCEPHALOGRAPHY	425		6		6,834	54,498	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			6,475		39,067	387,502	71
72	IMPL. DEV. CHARGED TO PATIENTS			2,182		1,880	33,423	72
73	DRUGS CHARGED TO PATIENTS				408,698	102,574	1,035,029	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					16,696	796,404	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	67,364		1,530		48,696	3,968,553	88
90	CLINIC	211				1,272	35,618	90
91	EMERGENCY	25,287	190,656	3,278		81,964	2,777,715	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	15,079	113,695	696		27,850	1,174,883	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)	237,109	914,116	89,150	408,698	820,802	20,075,563	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						19,628	190
192	PHYSICIANS' PRIVATE OFFICES	896					176,299	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	238,005	914,116	89,150	408,698	820,802	20,271,490	202

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
7.01	RHC UTILITY EXPENSE						7.01
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		2,909,980				30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		1,321,024				50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC		1,916,349				54
60	LABORATORY		2,315,463				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY		510,598				65
66	PHYSICAL THERAPY		713,001				66
69	ELECTROCARDIOLOGY		125,523				69
70	ELECTROENCEPHALOGRAPHY		54,498				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		387,502				71
72	IMPL. DEV. CHARGED TO PATIENTS		33,423				72
73	DRUGS CHARGED TO PATIENTS		1,035,029				73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		796,404				76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC		3,968,553				88
90	CLINIC		35,618				90
91	EMERGENCY		2,777,715				91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES		1,174,883				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)		20,075,563				118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		19,628				190
192	PHYSICIANS' PRIVATE OFFICES		176,299				192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)		20,271,490				202

Optimizer Systems, Inc.

Win LASH

Micro System

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2013 To: 02/28/2014	Run Date: 07/15/2014 Run Time: 15:49 Version: 2014.03
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS 0	CAP BLDG & FIXTURES 1	NEW RHC BUILDING FIXTURES 1.01	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL		313,554		422,944	736,498	736,498	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		5,427		7,321	12,748	26,165	7
7.01	RHC UTILITY EXPENSE						1,596	7.01
8	LAUNDRY & LINEN SERVICE						3,372	8
9	HOUSEKEEPING		3,952		5,331	9,283	14,895	9
10	DIETARY		16,715		22,547	39,262	7,029	10
11	CAFETERIA						8,647	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		3,397		4,582	7,979	32,314	13
14	CENTRAL SERVICES & SUPPLY		5,901		7,960	13,861	2,454	14
15	PHARMACY		5,685		7,668	13,353	14,091	15
16	MEDICAL RECORDS & LIBRARY		44,542		60,082	104,624	25,357	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		82,669		111,510	194,179	74,437	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		55,045		74,249	129,294	36,606	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC		40,658		54,842	95,500	55,235	54
60	LABORATORY		16,214		21,871	38,085	70,047	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		4,548		6,134	10,682	15,184	65
66	PHYSICAL THERAPY			43,782		43,782	23,805	66
69	ELECTROCARDIOLOGY		4,548		6,134	10,682	3,627	69
70	ELECTROENCEPHALOGRAPHY		4,534		6,116	10,650	1,292	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						12,424	71
72	IMPL. DEV. CHARGED TO PATIENTS						1,067	72
73	DRUGS CHARGED TO PATIENTS						19,029	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		34,946		47,138	82,084	25,063	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			121,786		121,786	134,718	88
90	CLINIC						1,240	90
91	EMERGENCY		37,829		51,027	88,856	86,442	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		16,837		22,711	39,548	35,397	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)		697,001	165,568	940,167	1,802,736	731,533	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,641		4,911	8,552	373	190
192	PHYSICIANS' PRIVATE OFFICES		17,866	12,439	24,098	54,403	4,592	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		718,508	178,007	969,176	1,865,691	736,498	202

Optimizer Systems, Inc.

Win LASH

Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		7	7.01	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	38,913						7
7.01	RHC UTILITY EXPENSE		1,596					7.01
8	LAUNDRY & LINEN SERVICE			3,372				8
9	HOUSEKEEPING	385			24,563			9
10	DIETARY	1,628			757	48,676		10
11	CAFETERIA						8,647	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	331			154		580	13
14	CENTRAL SERVICES & SUPPLY	575			267		27	14
15	PHARMACY	554			257		193	15
16	MEDICAL RECORDS & LIBRARY	4,338			2,016		303	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	8,051		3,372	3,742	48,676	1,397	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	5,361			2,492		479	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	3,960			1,840		449	54
60	LABORATORY	1,579			734		542	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	443			206		247	65
66	PHYSICAL THERAPY		393				385	66
69	ELECTROCARDIOLOGY	443			206		76	69
70	ELECTROENCEPHALOGRAPHY	442			205		15	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,404			1,582			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		1,091		6,657		2,446	88
90	CLINIC						8	90
91	EMERGENCY	3,684			1,712		919	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	1,640			762		548	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)	36,818	1,484	3,372	23,589	48,676	8,614	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	355			165			190
192	PHYSICIANS' PRIVATE OFFICES	1,740	112		809		33	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	38,913	1,596	3,372	24,563	48,676	8,647	202

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Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS
		13	14	15	16	24	25
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
7.01	RHC UTILITY EXPENSE						7.01
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	41,358					13
14	CENTRAL SERVICES & SUPPLY	257	17,441				14
15	PHARMACY		179	28,627			15
16	MEDICAL RECORDS & LIBRARY				136,638		16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	10,634	426		7,272	352,186	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	4,498	4,660		5,908	189,298	50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	4,211	1,025		30,113	192,333	54
60	LABORATORY	5,086	8,082		29,487	153,642	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	2,902	207		1,493	31,364	65
66	PHYSICAL THERAPY		87		5,981	74,433	66
69	ELECTROCARDIOLOGY		4		1,981	17,019	69
70	ELECTROENCEPHALOGRAPHY		1		1,138	13,743	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,267		6,503	20,194	71
72	IMPL. DEV. CHARGED TO PATIENTS		427		313	1,807	72
73	DRUGS CHARGED TO PATIENTS			28,627	17,074	64,730	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				2,779	114,912	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC		299		8,105	275,102	88
90	CLINIC				212	1,460	90
91	EMERGENCY	8,626	641		13,643	204,523	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	5,144	136		4,636	87,811	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)	41,358	17,441	28,627	136,638	1,794,557	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					9,445	190
192	PHYSICIANS' PRIVATE OFFICES					61,689	192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	41,358	17,441	28,627	136,638	1,865,691	202

Optimizer Systems, Inc.

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Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	TOTAL				
		26				
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT					1.01
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5	ADMINISTRATIVE & GENERAL					5
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
7.01	RHC UTILITY EXPENSE					7.01
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	352,186				30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	189,298				50
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC	192,333				54
60	LABORATORY	153,642				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	31,364				65
66	PHYSICAL THERAPY	74,433				66
69	ELECTROCARDIOLOGY	17,019				69
70	ELECTROENCEPHALOGRAPHY	13,743				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,194				71
72	IMPL. DEV. CHARGED TO PATIENTS	1,807				72
73	DRUGS CHARGED TO PATIENTS	64,730				73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	114,912				76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC	275,102				88
90	CLINIC	1,460				90
91	EMERGENCY	204,523				91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES	87,811				95
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
	SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)	1,794,557				118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,445				190
192	PHYSICIANS' PRIVATE OFFICES	61,689				192
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (sum of lines 118-201)	1,865,691				202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2013 To: 02/28/2014	Run Date: 07/15/2014 Run Time: 15:49 Version: 2014.03
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	NEW RHC BUILDING FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	
		1	1.01	2	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	53,087						1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT		15,885					1.01
2	CAP REL COSTS-MVBLE EQUIP			53,087				2
4	EMPLOYEE BENEFITS DEPARTMENT				9,089,013			4
5	ADMINISTRATIVE & GENERAL	23,167		23,167	834,340	-3,386,409	16,885,081	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	401		401	157,543		599,874	7
7.01	RHC UTILITY EXPENSE						36,580	7.01
8	LAUNDRY & LINEN SERVICE						77,318	8
9	HOUSEKEEPING	292		292	206,842		341,489	9
10	DIETARY	1,235		1,235	54,923		161,138	10
11	CAFETERIA				141,231		198,246	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	251		251	515,580		740,851	13
14	CENTRAL SERVICES & SUPPLY	436		436	24,391		56,252	14
15	PHARMACY	420		420	172,075		323,052	15
16	MEDICAL RECORDS & LIBRARY	3,291		3,291	269,741		581,340	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,108		6,108	1,242,827		1,706,575	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,067		4,067	426,306		839,250	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	3,004		3,004	399,096		1,266,346	54
60	LABORATORY	1,198		1,198	481,958		1,605,916	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	336		336	220,048		348,108	65
66	PHYSICAL THERAPY		3,907		342,548		545,768	66
69	ELECTROCARDIOLOGY	336		336	67,479		83,148	69
70	ELECTROENCEPHALOGRAPHY	335		335	13,753		29,632	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						284,835	71
72	IMPL. DEV. CHARGED TO PATIENTS						24,456	72
73	DRUGS CHARGED TO PATIENTS						436,262	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582		2,582			574,612	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		10,868		2,177,604		3,088,446	88
90	CLINIC				6,807		28,433	90
91	EMERGENCY	2,795		2,795	817,472		1,981,802	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	1,244		1,244	487,489		811,517	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	9,060,053	-3,386,409	16,771,246	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	269		269			8,552	190
192	PHYSICIANS' PRIVATE OFFICES	1,320	1,110	1,320	28,960		105,283	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	718,508	178,007	969,176	3,251,119		3,386,409	202
203	UNIT COST MULT-WS B PT I	13.534538	11.205980	18.256372	0.357698		0.200556	203
204	COST TO BE ALLOC PER B PT II						736,498	204
205	UNIT COST MULT-WS B PT II						0.043618	205

Optimizer Systems, Inc.

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION	RHC	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
		OF PLANT	UTILITY	& LINEN	KEEPING	PATIENT	GROSS	
		SQUARE	EXPENSE	SERVICE	SQUARE	DAY	SALARIES	
		FEET	SQUARE	PATIENT	FEET	DAYS		
		7	FEET	DAYS	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	29,519						7
7.01	RHC UTILITY EXPENSE		15,885					7.01
8	LAUNDRY & LINEN SERVICE			2,918				8
9	HOUSEKEEPING	292			40,095			9
10	DIETARY	1,235			1,235	2,918		10
11	CAFETERIA						7,694,134	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	251			251		515,580	13
14	CENTRAL SERVICES & SUPPLY	436			436		24,391	14
15	PHARMACY	420			420		172,075	15
16	MEDICAL RECORDS & LIBRARY	3,291			3,291		269,741	16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	6,108		2,918	6,108	2,918	1,242,827	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,067			4,067		426,306	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	3,004			3,004		399,096	54
60	LABORATORY	1,198			1,198		481,958	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	336			336		220,048	65
66	PHYSICAL THERAPY		3,907				342,548	66
69	ELECTROCARDIOLOGY	336			336		67,479	69
70	ELECTROENCEPHALOGRAPHY	335			335		13,753	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582			2,582			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		10,868		10,868		2,177,604	88
90	CLINIC						6,807	90
91	EMERGENCY	2,795			2,795		817,472	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	1,244			1,244		487,489	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	27,930	14,775	2,918	38,506	2,918	7,665,174	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	269			269			190
192	PHYSICIANS' PRIVATE OFFICES	1,320	1,110		1,320		28,960	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	720,182	43,916	92,825	417,101	236,433	238,005	202
203	UNIT COST MULT-WS B PT I	24,397,236	2,764,621	31,811,172	10,402,818	81,025,703	0.030933	203
204	COST TO BE ALLOC PER B PT II	38,913	1,596	3,372	24,563	48,676	8,647	204
205	UNIT COST MULT-WS B PT II	1.318236	0.100472	1.155586	0.612620	16.681289	0.001124	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION DIRECT NRSNG HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE
	13	14	15	16

GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT				1	
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT				1.01	
2	CAP REL COSTS-MVBLE EQUIP				2	
4	EMPLOYEE BENEFITS DEPARTMENT				4	
5	ADMINISTRATIVE & GENERAL				5	
6	MAINTENANCE & REPAIRS				6	
7	OPERATION OF PLANT				7	
7.01	RHC UTILITY EXPENSE				7.01	
8	LAUNDRY & LINEN SERVICE				8	
9	HOUSEKEEPING				9	
10	DIETARY				10	
11	CAFETERIA				11	
12	MAINTENANCE OF PERSONNEL				12	
13	NURSING ADMINISTRATION	3,919,444			13	
14	CENTRAL SERVICES & SUPPLY	24,391	999,017		14	
15	PHARMACY		10,279	372,974	15	
16	MEDICAL RECORDS & LIBRARY			46,374,913	16	
17	SOCIAL SERVICE				17	
19	NONPHYSICIAN ANESTHETISTS				19	
20	NURSING SCHOOL				20	
21	I&R SERVICES-SALARY & FRINGES APPRVD				21	
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				22	
23	PARAMED ED PRGM-(SPECIFY)				23	
INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	1,007,672	24,377		2,468,517	30
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	426,304	266,936		2,005,339	50
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC	399,098	58,715		10,215,939	54
60	LABORATORY	481,958	462,942		10,009,315	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	275,058	11,833		506,744	65
66	PHYSICAL THERAPY		4,973		2,030,354	66
69	ELECTROCARDIOLOGY		205		672,487	69
70	ELECTROENCEPHALOGRAPHY		67		386,120	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		72,558		2,207,295	71
72	IMPL. DEV. CHARGED TO PATIENTS		24,456		106,213	72
73	DRUGS CHARGED TO PATIENTS			372,974	5,795,490	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				943,331	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		17,145		2,751,353	88
90	CLINIC				71,868	90
91	EMERGENCY	817,473	36,735		4,631,017	91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES	487,490	7,796		1,573,531	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)	3,919,444	999,017	372,974	46,374,913	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	914,116	89,150	408,698	820,802	202
203	UNIT COST MULT-WS B PT I	0.233226	0.089238	1.095781	0.017699	203
204	COST TO BE ALLOC PER B PT II	41,358	17,441	28,627	136,638	204
205	UNIT COST MULT-WS B PT II	0.010552	0.017458	0.076753	0.002946	205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS		
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS
		1	2	3	4	5
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	2,909,980		2,909,980		30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	1,321,024		1,321,024		50
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC	1,916,349		1,916,349		54
60	LABORATORY	2,315,463		2,315,463		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	510,598		510,598		65
66	PHYSICAL THERAPY	713,001		713,001		66
69	ELECTROCARDIOLOGY	125,523		125,523		69
70	ELECTROENCEPHALOGRAPHY	54,498		54,498		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	387,502		387,502		71
72	IMPL. DEV. CHARGED TO PATIENTS	33,423		33,423		72
73	DRUGS CHARGED TO PATIENTS	1,035,029		1,035,029		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	796,404		796,404		76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC	3,968,553		3,968,553		88
90	CLINIC	35,618		35,618		90
91	EMERGENCY	2,777,715		2,777,715		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	105,265		105,265		92
	OTHER REIMBURSABLE COST CENTERS					
95	AMBULANCE SERVICES	1,174,883		1,174,883		95
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	20,180,828		20,180,828		200
201	LESS OBSERVATION BEDS	105,265		105,265		201
202	TOTAL (SEE INSTRUCTIONS)	20,075,563		20,075,563		202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	2,087,508		2,087,508				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	328,220	1,677,119	2,005,339	0.658753			50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	663,797	9,552,142	10,215,939	0.187584			54
60	LABORATORY	1,465,930	8,543,385	10,009,315	0.231331			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	355,020	151,724	506,744	1.007605			65
66	PHYSICAL THERAPY	230,680	1,799,674	2,030,354	0.351171			66
69	ELECTROCARDIOLOGY	43,562	628,925	672,487	0.186655			69
70	ELECTROENCEPHALOGRAPHY	4,757	381,363	386,120	0.141143			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	929,514	1,277,781	2,207,295	0.175555			71
72	IMPL. DEV. CHARGED TO PATIENTS	18,590	87,623	106,213	0.314679			72
73	DRUGS CHARGED TO PATIENTS	2,524,346	3,271,144	5,795,490	0.178592			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		943,331	943,331	0.844247			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		2,751,353	2,751,353				88
90	CLINIC		71,868	71,868	0.495603			90
91	EMERGENCY	108,581	4,522,436	4,631,017	0.599807			91
92	OBSERVATION BEDS (NON-DISTINCT PART)		381,009	381,009	0.276280			92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES		1,573,531	1,573,531	0.746654			95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	SUBTOTAL (SEE INSTRUCTIONS)	8,760,505	37,614,408	46,374,913				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		37,614,408	46,374,913				202

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Micro System

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1351

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.658753		867,634			571,557		50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.187584		3,824,013			717,324		54
60	LABORATORY	0.231331		4,196,037			970,673		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	1.007605		61,832			62,302		65
66	PHYSICAL THERAPY	0.351171		553,636			194,421		66
69	ELECTROCARDIOLOGY	0.186655		326,663			60,973		69
70	ELECTROENCEPHALOGRAPHY	0.141143		171,176			24,160		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175555		461,277			80,979		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.314679		72,400			22,783		72
73	DRUGS CHARGED TO PATIENTS	0.178592		1,578,427			281,894		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.844247		925,342			781,217		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
90	CLINIC	0.495603		31,346			15,535		90
91	EMERGENCY	0.599807		1,555,835			933,201		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.276280		109,730			30,316		92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.746654							95
200	SUBTOTAL (see instructions)			14,735,348			4,747,335		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			14,735,348			4,747,335		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2013 To: 02/28/2014	Run Date: 07/15/2014 Run Time: 15:49 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z351

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.658753							50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.187584							54
60	LABORATORY	0.231331							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	1.007605							65
66	PHYSICAL THERAPY	0.351171							66
69	ELECTROCARDIOLOGY	0.186655							69
70	ELECTROENCEPHALOGRAPHY	0.141143							70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175555							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.314679							72
73	DRUGS CHARGED TO PATIENTS	0.178592							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.844247							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
90	CLINIC	0.495603							90
91	EMERGENCY	0.599807							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.276280							92
	OTHER REIMBURSABLE COST CENTERS								
95	AMBULANCE SERVICES	0.746654							95
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] TRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	3,732	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,053	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,918	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	566	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)	113	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,165	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)	566	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)	113	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)	2,909,980	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)	529,443	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,380,537	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,380,537	37

Optimizer Systems, Inc.

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
							779.74	38
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)						1,688,137	39
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)							40
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						1,688,137	41
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)							
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 + col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)		
		1	2	3	4	5		
42	NURSERY (Titles V and XIX only)							42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
43	INTENSIVE CARE UNIT							43
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						1,150,511	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						2,838,648	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)							50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)							51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)							52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)							53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						441,333	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						88,111	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						529,444	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

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

						135	87
						779.74	88
						105,265	89
		COST	ROUTINE COST (from line 27)	column 1 + column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
87	TOTAL OBSERVATION BED DAYS (see instructions)						
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						
90	CAPITAL-RELATED COST	352,186	2,380,537	0.147944	105,265	15,573	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1351

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

		RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,533,426		30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.658753	306,950	202,204	50
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.187584	361,609	67,832	54
60	LABORATORY	0.231331	954,793	220,873	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	1.007605	216,495	218,141	65
66	PHYSICAL THERAPY	0.351171	94,906	33,328	66
69	ELECTROCARDIOLOGY	0.186655	39,230	7,322	69
70	ELECTROENCEPHALOGRAPHY	0.141143	778	110	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175555	644,010	113,059	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.314679	12,405	3,904	72
73	DRUGS CHARGED TO PATIENTS	0.178592	1,575,133	281,306	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.844247			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
90	CLINIC	0.495603			90
91	EMERGENCY	0.599807	4,054	2,432	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.276280			92
	OTHER REIMBURSABLE COST CENTERS				
95	AMBULANCE SERVICES				95
200	TOTAL (sum of lines 50-94, and 96-98)		4,210,363	1,150,511	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		4,210,363		202

(A) Worksheet A line numbers

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z351

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX IRF NF ICF/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				30
30	ADULTS & PEDIATRICS				43
43	NURSERY				
	ANCILLARY SERVICE COST CENTERS				50
50	OPERATING ROOM	0.658753			53
53	ANESTHESIOLOGY				54
54	RADIOLOGY-DIAGNOSTIC	0.187584	32,942	6,179	60
60	LABORATORY	0.231331	190,991	44,182	62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				65
65	RESPIRATORY THERAPY	1.007605	68,829	69,352	66
66	PHYSICAL THERAPY	0.351171	129,979	45,645	69
69	ELECTROCARDIOLOGY	0.186655	2,989	558	70
70	ELECTROENCEPHALOGRAPHY	0.141143			71
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.175555	100,945	17,721	72
72	IMPL. DEV. CHARGED TO PATIENTS	0.314679			73
73	DRUGS CHARGED TO PATIENTS	0.178592	399,858	71,411	76
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.844247			76.97
76.97	CARDIAC REHABILITATION				76.98
76.98	HYPERBARIC OXYGEN THERAPY				76.99
76.99	LITHOTRIPSY				
	OUTPATIENT SERVICE COST CENTERS				88
88	RURAL HEALTH CLINIC				90
90	CLINIC	0.495603			91
91	EMERGENCY	0.599807			92
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.276280			
	OTHER REIMBURSABLE COST CENTERS				95
95	AMBULANCE SERVICES				200
200	TOTAL (sum of lines 50-94, and 96-98)		926,533	255,048	201
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				202
202	NET CHARGES (line 200 minus line 201)		926,533		

(A) Worksheet A line numbers

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1351

WORKSHEET E
PART B

CHECK APPLICABLE BOX: HOSPITAL IPF IRF SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	4,747,335		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)			2
3	PPS PAYMENTS			3
4	OUTLIER PAYMENT (see instructions)			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)			5
6	LINE 2 TIMES LINE 5			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)			8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200			9
10	ORGAN ACQUISITION			10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	4,747,335		11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
12	ANCILLARY SERVICE CHARGES			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)			13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)			14
	CUSTOMARY CHARGES			
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)			17
18	TOTAL CUSTOMARY CHARGES (see instructions)			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))			20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	4,794,808		21
22	INTERNS AND RESIDENTS (see instructions)			22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)			23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	DEDUCTIBLES AND COINSURANCE (see instructions)	43,481		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	2,123,909		26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,627,418		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)	2,627,418		29
30	SUBTOTAL (sum of lines 27 through 29)	56		30
31	PRIMARY PAYER PAYMENTS	2,627,362		31
32	SUBTOTAL (line 30 minus line 31)			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)			33
34	ALLOWABLE BAD DEBTS (see instructions)	589,165		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	518,465		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	589,165		36
37	SUBTOTAL (see instructions)	3,145,827		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			39
40	SUBTOTAL (see instructions)	3,145,827		40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	57,569		40.01
41	INTERIM PAYMENTS	2,977,161		41
42	TENTATIVE SETTLEMENT (for contractor use only)			42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	111,097		43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)			90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)			91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY			92
93	TIME VALUE OF MONEY (see instructions)			93
94	TOTAL (sum of lines 91 and 93)			94

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1351

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,469,288		3,021,535	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					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. (1)					
		.01	10/28/2013	114,760		3.01
		.02				3.02
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50	04/16/2013	25,093	08/22/2013	5,986
		.51	08/22/2013	51,002	10/28/2013	36,852
		.52	02/28/2014	76,015	02/28/2014	1,536
		.53				3.53
		.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		-37,350		-44,374
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			2,431,938		2,977,161
						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. (1)					
		.01				5.01
		.02				5.02
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.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	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01				6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					7
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z351

WORKSHEET E-1
PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOXES: [] IRF [XX] SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		733,522			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					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.01	08/22/2013			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.02				3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
						3.52
		PROVIDER				3.53
		TO				3.54
		PROGRAM				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)	.99		32,323		
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			765,845		4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	.01				5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	.02				5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		PROVIDER				5.52
		TO				5.53
		PROGRAM				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)	.99				6.01
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01				6.02
		.02				7
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					8
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL [] 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	755	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,165	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	2,918	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	46,374,913	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,094,606	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
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z351

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES: [] TITLE XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

	PART A	PART B	
	1	2	
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	534,738		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)	257,598		3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5 PROGRAM DAYS	679		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)	792,336		8
9 PRIMARY PAYER PAYMENTS (see instructions)			9
10 SUBTOTAL (line 8 minus line 9)	792,336		10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12 SUBTOTAL (line 10 minus line 11)	792,336		12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	7,916		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)	784,420		15
16 OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
17 ALLOWABLE BAD DEBTS (see instructions)			17
17.01 ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			17.01
18 ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			18
19 TOTAL (see instructions)	784,420		19
19.01 SEQUESTRATION ADJUSTMENT (see instructions)	14,355		19.01
20 INTERIM PAYMENTS	765,845		20
21 TENTATIVE SETTLEMENT (for contractor use only)			21
22 BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	4,220		22
23 PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

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CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2013 To: 02/28/2014	Run Date: 07/15/2014 Run Time: 15:49 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

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

1	INPATIENT SERVICES	2,838,648	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	2,838,648	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	2,867,034	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (not to exceed 1.000000)	0.000000	13
14	TOTAL CUSTOMARY CHARGES (see instructions)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 14 exceeds line 6) (see instructions)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 6 exceeds line 14) (see instructions)		16
17	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	2,867,034	19
20	DEDUCTIBLES (exclude professional component)	393,818	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	2,473,216	22
23	COINSURANCE	919	23
24	SUBTOTAL (line 22 minus line 23)	2,472,297	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	82,374	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	72,489	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	82,374	27
28	SUBTOTAL (sum of lines 24 and 26)	2,544,786	28
29	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		29
30	SUBTOTAL (line 28 plus or minus line 29)	2,544,786	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	46,570	30.01
31	INTERIM PAYMENTS	2,431,938	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	66,278	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

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BALANCE SHEET

WORKSHEET G

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

ASSETS (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
CURRENT ASSETS		1	2	3	4	
1	CASH ON HAND AND IN BANKS	2,365,179				1
2	TEMPORARY INVESTMENTS	2,521,017				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3,897,455				4
5	OTHER RECEIVABLES	19,206				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE					6
7	INVENTORY	207,539				7
8	PREPAID EXPENSES	292,085				8
9	OTHER CURRENT ASSETS					9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	9,302,481				11
FIXED ASSETS						
12	LAND	132,111				12
13	LAND IMPROVEMENTS	347,032				13
14	ACCUMULATED DEPRECIATION	-272,632				14
15	BUILDINGS	12,554,850				15
16	ACCUMULATED DEPRECIATION	-8,069,011				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	8,897,213				19
20	ACCUMULATED DEPRECIATION	-6,710,199				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)	6,879,364				30
OTHER ASSETS						
31	INVESTMENTS					31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	5,949,862				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	5,949,862				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	22,131,707				36
LIABILITIES AND FUND BALANCES (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
CURRENT LIABILITIES		1	2	3	4	
37	ACCOUNTS PAYABLE	1,640,159				37
38	SALARIES, WAGES & FEES PAYABLE	643,948				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	334,678				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	2,618,785				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	3,910,693				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	3,910,693				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	6,529,478				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	15,602,229				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	15,602,229				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	22,131,707				60

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		15,843,721			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		-241,493			2
3	TOTAL (sum of line 1 and line 2)		15,602,228			3
4	ADDITIONS (credit adjustments)	1				4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		1			10
11	SUBTOTAL (line 3 plus line 10)		15,602,229			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)		15,602,229			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	2,292,684		2,292,684	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	2,292,684		2,292,684	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	2,292,684		2,292,684	17
18	ANCILLARY SERVICES	6,908,659		6,908,659	18
19	OUTPATIENT SERVICES		36,520,625	36,520,625	19
20	RHC		3,193,060	3,193,060	20
20.01	RHC II				20.01
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE		1,573,531	1,573,531	23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	9,201,343	41,287,216	50,488,559	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		22,323,304	29
30	INTEREST EXPENSE			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		22,323,304	43

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	50,488,559	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	29,174,718	2
3	NET PATIENT REVENUES (line 1 minus line 2)	21,313,841	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	22,323,304	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-1,009,463	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	136,432	6
7	INCOME FROM INVESTMENTS	52,618	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	115,149	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES 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	7,253	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)	203,898	24
24.01	OTHER (RENTAL INCOME)	54,250	24.01
24.02	OTHER (MISCELLANEOUS INCOME)	18,779	24.02
24.03	OTHER (GRANT INCOME)	94,591	24.03
24.04	OTHER (EHR INCENTIVE)	85,000	24.04
25	TOTAL OTHER INCOME (sum of lines 6-24)	767,970	25
26	TOTAL (line 5 plus line 25)	-241,493	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	-241,493	29

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5	ADMINISTRATIVE & GENERAL						5
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
7.01	RHC UTILITY EXPENSE						7.01
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC						88
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
95	AMBULANCE SERVICES						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202

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

COMPONENT CCN: 14-3458

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	988,228		988,228		988,228	-224,641	763,587	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	279,471		279,471		279,471		279,471	3
4 VISITING NURSE								4
5 OTHER NURSE	526,356		526,356		526,356		526,356	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	3,587		3,587		3,587		3,587	9
10 SUBTOTAL (sum of lines 1-9)	1,797,642		1,797,642		1,797,642	-224,641	1,573,001	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT		24,157	24,157		24,157		24,157	11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT		89,518	89,518		89,518		89,518	13
14 SUBTOTAL (sum of lines 11-13)		113,675	113,675		113,675		113,675	14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		41,019	41,019		41,019		41,019	15
16 TRANSPORTATION (Health Care Staff)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		26,824	26,824		26,824		26,824	18
19 OTHER HEALTH CARE COSTS		57,309	57,309		57,309	-4,050	53,259	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (sum of lines 15-20)		125,152	125,152		125,152	-4,050	121,102	21
22 TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	1,797,642	238,827	2,036,469		2,036,469	-228,691	1,807,778	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS	379,962		379,962		379,962		379,962	29
30 ADMINISTRATIVE COSTS								30
31 TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	379,962		379,962		379,962		379,962	31
32 TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	2,177,604	238,827	2,416,431		2,416,431	-228,691	2,187,740	32

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

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3458

WORKSHEET M-2

CHECK APPLICABLE BOX: RHC FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	2.77	13,180	4,200	11,634		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	4.02	11,684	2,100	8,442		3
4	SUBTOTAL (sum of lines 1-3)	6.79	24,864		20,076	24,864	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FQHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FQHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	6.79	24,864			24,864	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		9				9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)		1,807,778	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)			11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)		1,807,778	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)		1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)		379,962	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)		1,780,813	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)		2,160,775	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)			17
18	SUBTRACT LINE 17 FROM LINE 16		2,160,775	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)		2,160,775	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)		3,968,553	20

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3458

WORKSHEET M-3

CHECK [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 Worksheet M-2, line 20)	3,968,553	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	15,083	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	3,953,470	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	24,864	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)	9	5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	24,873	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	158.95	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	158.95	158.95	158.95	9
CALCULATION OF SETTLEMENT					
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		7,143		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		1,135,380		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, columns 1, 2, and 3)		1,135,380		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)				16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		847,057		16.04
16.05	TOTAL PROGRAM COST (see instructions)		847,057		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		76,559		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		150,194		19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		847,057		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		15,082		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		862,139		22
23	ALLOWABLE BAD DEBTS (see instructions)		45,156		23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		45,156		24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		901,876		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		16,504		26.01
27	INTERIM PAYMENTS		893,949		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		-8,577		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

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

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3458

WORKSHEET M-4

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

		PNEUMO- COCCAL 1	INFLUENZA 2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	1,573,001	1,573,001	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000083	0.000920	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	131	1,447	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	924	4,368	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	1,055	5,815	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	1,807,778	1,807,778	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	2,160,775	2,160,775	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.000584	0.003217	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	1,262	6,951	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	2,317	12,766	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	14	156	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	165.50	81.83	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	14	156	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	2,317	12,765	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		15,083	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		15,082	16

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

COMPONENT CCN: 14-3458

WORKSHEET M-5

CHECK APPLICABLE BOX: RHC FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			871,209	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				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. (1)				
		.01	08/22/2013	22,740	3.01
		.02			3.02
		PROGRAM			3.03
		TO			3.04
		PROVIDER			3.05
					3.06
					3.07
					3.08
					3.09
					3.10
					3.50
					3.51
		PROVIDER			3.52
		TO			3.53
		PROGRAM			3.54
					3.55
					3.56
					3.57
					3.58
					3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		22,740	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)			893,949	
	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. (1)				
		.01			5.01
		.02			5.02
		PROGRAM			5.03
		TO			5.04
		PROVIDER			5.05
					5.06
					5.07
					5.08
					5.09
					5.10
					5.50
					5.51
		PROVIDER			5.52
		TO			5.53
		PROGRAM			5.54
					5.55
					5.56
					5.57
					5.58
					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01			6.01
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)		8

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

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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6		
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	70.91		9.27				80.18	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	15.31	43.27					58.58	50
54	RADIOLOGY-DIAGNOSTIC	3.54	37.43					40.97	54
60	LABORATORY	9.54	41.92					51.46	60
65	RESPIRATORY THERAPY	42.72	12.20					54.92	65
66	PHYSICAL THERAPY	4.67	27.27					31.94	66
69	ELECTROCARDIOLOGY	5.83	48.58					54.41	69
70	ELECTROENCEPHALOGRAPHY	0.20	44.33					44.53	70
71	MEDICAL SUPPLIES CHARGED TO PAT	29.18	20.90					50.08	71
72	IMPL. DEV. CHARGED TO PATIENTS	11.68	68.16					79.84	72
73	DRUGS CHARGED TO PATIENTS	27.18	27.24					54.42	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI		98.09					98.09	76
90	CLINIC		43.62					43.62	90
91	EMERGENCY	0.09	33.60					33.69	91
92	OBSERVATION BEDS (NON-DISTINCT		28.80					28.80	92
200	TOTAL CHARGES	9.51	33.27					42.78	200

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REPORT 97 - UTILIZATION STATISTICS - SWING-BED SNF / NF

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6		
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	RADIOLOGY-DIAGNOSTIC	0.32						0.32	54
60	LABORATORY	1.91						1.91	60
65	RESPIRATORY THERAPY	13.58						13.58	65
66	PHYSICAL THERAPY	6.40						6.40	66
69	ELECTROCARDIOLOGY	0.44						0.44	69
71	MEDICAL SUPPLIES CHARGED TO PAT	4.57						4.57	71
73	DRUGS CHARGED TO PATIENTS	6.90						6.90	73
200	TOTAL CHARGES	2.09						2.09	200

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REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	718,508	3.54	-718,508	-7.31			1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	178,007	0.88	-178,007	-1.81			1.01
2	CAP REL COSTS-MVBLE EQUIP	969,176	4.78	-969,176	-9.86			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	3,251,119	16.04	-3,251,119	-33.07			4
5	ADMINISTRATIVE & GENERAL	2,351,469	11.60	-2,351,469	-23.92			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	530,773	2.62	-530,773	-5.40			7
7.01	RHC UTILITY EXPENSE	36,580	0.18	-36,580	-0.37			7.01
8	LAUNDRY & LINEN SERVICE	77,318	0.38	-77,318	-0.79			8
9	HOUSEKEEPING	258,219	1.27	-258,219	-2.63			9
10	DIETARY	102,230	0.50	-102,230	-1.04			10
11	CAFETERIA	147,728	0.73	-147,728	-1.50			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	548,450	2.71	-548,450	-5.58			13
14	CENTRAL SERVICES & SUPPLY	33,666	0.17	-33,666	-0.34			14
15	PHARMACY	248,148	1.22	-248,148	-2.52			15
16	MEDICAL RECORDS & LIBRARY	380,230	1.88	-380,230	-3.87			16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	ADULTS & PEDIATRICS	1,067,839	5.27	1,842,141	18.74	2,909,980	14.36	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	557,467	2.75	763,557	7.77	1,321,024	6.52	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	1,028,090	5.07	888,259	9.03	1,916,349	9.45	54
60	LABORATORY	1,395,436	6.88	920,027	9.36	2,315,463	11.42	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	258,715	1.28	251,883	2.56	510,598	2.52	65
66	PHYSICAL THERAPY	379,457	1.87	333,544	3.39	713,001	3.52	66
69	ELECTROCARDIOLOGY	48,329	0.24	77,194	0.79	125,523	0.62	69
70	ELECTROENCEPHALOGRAPHY	14,063	0.07	40,435	0.41	54,498	0.27	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	284,835	1.41	102,667	1.04	387,502	1.91	71
72	IMPL. DEV. CHARGED TO PATIENTS	24,456	0.12	8,967	0.09	33,423	0.16	72
73	DRUGS CHARGED TO PATIENTS	436,262	2.15	598,767	6.09	1,035,029	5.11	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	492,528	2.43	303,876	3.09	796,404	3.93	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88	RURAL HEALTH CLINIC	2,187,740	10.79	1,780,813	18.11	3,968,553	19.58	88
90	CLINIC	25,998	0.13	9,620	0.10	35,618	0.18	90
91	EMERGENCY	1,600,538	7.90	1,177,177	11.97	2,777,715	13.70	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
95	AMBULANCE SERVICES	597,595	2.95	577,288	5.87	1,174,883	5.80	95
	OUTPATIENT SERVICE COST CENTERS							
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							
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			19,628	0.20	19,628	0.10	190
192	PHYSICIANS' PRIVATE OFFICES	40,521	0.20	135,778	1.38	176,299	0.87	192
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	20,271,490	100.00			20,271,490	100.00	202

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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)
3. RATIO OF COST TO CHARGES (line 1 / line 2)