

CLAY COUNTY HOSPITAL
FLORA, ILLINOIS
MEDICARE COST REPORT
YEAR ENDED FEBRUARY 28, 2015

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:57 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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: 07/27/2015 Time: 14:57 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 checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLAY COUNTY HOSPITAL (14-1351) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 03/01/2014 and ending 02/28/2015, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 07/27/2015 14:57
 BJoVs6KI2FMBw0cHDpl5Qh.Ld.E6N0
 KxZFc0:wfxEgKLLhSeo1ogOx07MJC
 d95e04oZn4099hw0

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

 Title

PI Encryption: 07/27/2015 14:57
 WZKNHj2yrRBto57OvQE3R1i0sVX:N0
 aR6T30GejCEvohyasJroE9A5qtm8
 q.RP0Xmd4E0zZr.B

 Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII						
		TITLE V	PART A		PART B	HIT	TITLE XIX	
		1	2	3		4	5	
1	HOSPITAL		141,940	-309,530		641,003	254,635	1
2	SUBPROVIDER - IPF							2
3	SUBPROVIDER - IRF							3
4	SUBPROVIDER (OTHER)							4
5	SWING BED - SNF		28,711					5
6	SWING BED - NF							6
7	SKILLED NURSING FACILITY							7
8	NURSING FACILITY							8
9	HOME HEALTH AGENCY							9
10	HEALTH CLINIC - RHC			25,753				10
10.01	HEALTH CLINIC - RHC II							10.01
11	HEALTH CLINIC - FOHC							11
12	OUTPATIENT REHABILITATION PROVIDER							12
200	TOTAL		170,651	-283,777		641,003	254,635	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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	CLAY COUNTY HOSPITAL	14-1351	99914	1	12 / 21 / 2005	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	CLAY COUNTY SWING BED	14-Z351	99914		12 / 21 / 2005	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	CLAY COUNTY MEDICAL CLINIC	14-3458	99914		11 / 29 / 2005	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	LOUISVILLE MEDICAL CLINIC	14-3487	99914		12 / 18 / 2006	N	O	N	15.01
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 / 2014	To: 02 / 28 / 2015	20
21	Type of control (see instructions)	9		21

Inpatient PPS Information		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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:				38

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
----	--	---	--	--	----

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2)	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4)
	1	2	3	4	5
67					67

Inpatient Psychiatric 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N			80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N			81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N			85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	I	2	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	Y	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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
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	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.		N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, Section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance
		118,000		
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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	1 N	2	140
-----	--	--------	---	-----

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are the 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		Title V	Title XIX	
		Part A	Part B	3	4	
		1	2			
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	699,182			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)	07 / 01 / 2014	09 / 30 / 2014		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		Y		171

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

Provider Organization and Operation		Y/N	Date		
		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 in 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	
		1	2
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		Y/N	
		1	2
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	04/22/2015	Y	04/22/2015
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	

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

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

Capital Related Cost		
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	N 22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N 23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	Y 24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N 25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N 26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N 27

Interest Expense		
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N 28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	Y 29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N 30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N 31

Purchased Services		
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	Y 32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	Y 33

Provider-Based Physicians		
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y 34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y 35

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information			
41	First name: MARK	Last name: W	Title: DALLAS 41
42	Employer: KERBER, ECK, & BRAECKEL		42
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM 43	

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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		2,280	360	3,276	1
2	HMO and other (see instructions)						66			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						1,029		1,029	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		18	6,570	157,680.00		3,309	360	4,305	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		3,309	360	4,305	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					6,437		25,699	26
26.01	RHC II	88.01								26.01
27	Total (sum of lines 14-26)		18							27
28	Observation Bed Days							26	134	28
29	Ambulance Trips						1,121			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents 9	Employees On Payroll 10	Nonpaid Workers 11	Title V 12	Title XVIII 13	Title XIX 14	Total All Patients 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)					666	114	956	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)		177.30			666	114	956	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		32.20						26
26.01	RHC II								26.01
27	Total (sum of lines 14-26)		209.50						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	01/25/1985	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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)	0.405298	1
---	--	----------	---

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,486,294	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	12,674,094	6
7	Medicaid cost (line 1 times line 6)	5,136,785	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	1,650,491	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.		12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)		13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)		14
15	State or local indigent care program cost (line 1 times line 14)		15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.		16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care	123,052	17
18	Government grants, appropriations of transfers for support of hospital operations	278,688	18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,650,491	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	351,151	1,142,794	1,493,945	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	142,321	463,172	605,493	21
22	Partial payment by patients approved for charity care	184,510	767,238	951,748	22
23	Cost of charity care (line 21 minus line 22)	-42,189	-304,066	-346,255	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,974,821	26
27	Medicare bad debts for the entire hospital complex (see instructions)	399,412	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,575,409	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,043,808	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	697,553	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,348,044	31

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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		886,099	886,099	-151,120	734,979	-81,497	653,482	1
1.01	00101 NEW CAP RHC REL COSTS-BLDG & FIXT		4,040	4,040	145,677	149,717		149,717	1.01
2	00200 Cap Rel Costs-Mvble Equip		936,527	936,527	5,443	941,970		941,970	2
3	00300 Other Cap Rel Costs							-0-	3
4	00400 Employee Benefits Department	142,866	3,351,897	3,494,763		3,494,763	-95,899	3,398,864	4
5	00500 Administrative & General	1,127,894	2,384,999	3,512,893	-117,500	3,395,393	-354,276	3,041,117	5
6	00600 Maintenance & Repairs								6
7	00700 Operation of Plant	231,172	464,569	695,741		695,741		695,741	7
7.01	00701 RHC UTILITY EXPENSE		38,905	38,905		38,905		38,905	7.01
8	00800 Laundry & Linen Service		88,115	88,115		88,115		88,115	8
9	00900 Housekeeping	227,537	54,828	282,365		282,365		282,365	9
10	01000 Dietary	207,749	149,775	357,524	-252,284	105,240		105,240	10
11	01100 Cafeteria				252,284	252,284	-129,603	122,681	11
12	01200 Maintenance of Personnel								12
13	01300 Nursing Administration	452,909	54,137	507,046	117,500	624,546		624,546	13
14	01400 Central Services & Supply	28,934	18,327	47,261		47,261		47,261	14
15	01500 Pharmacy	195,845	43,303	239,148		239,148		239,148	15
16	01600 Medical Records & Library	296,072	105,950	402,022		402,022	-2,948	399,074	16
17	01700 Social Service								17
19	01900 Nonphysician Anesthetists								19
20	02000 Nursing School								20
21	02100 I&R Services-Salary & Fringes Apprvd								21
22	02200 I&R Services-Other Prgm Costs Apprvd								22
23	02300 Paramed Ed Prgm-(specify)								23
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000 Adults & Pediatrics	1,402,206	97,147	1,499,353		1,499,353	-273,378	1,225,975	30
	ANCILLARY SERVICE COST CENTERS								
50	05000 Operating Room	779,449	205,655	985,104	11,016	996,120		996,120	50
53	05300 Anesthesiology		355,356	355,356	-11,016	344,340	-344,340		53
54	05400 Radiology-Diagnostic	405,889	685,105	1,090,994		1,090,994		1,090,994	54
60	06000 Laboratory	464,431	1,041,374	1,505,805		1,505,805		1,505,805	60
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500 Respiratory Therapy	304,386	55,545	359,931	-60,877	299,054	-2,369	296,685	65
66	06600 Physical Therapy	410,372	45,834	456,206		456,206		456,206	66
69	06900 Electrocardiology	19,820	14,178	33,998	45,658	79,656	-19,820	59,836	69
70	07000 Electroencephalography		50,764	50,764	15,219	65,983	-50,750	15,233	70
71	07100 Medical Supplies Charged to Patients		440,076	440,076	-28,178	411,898	-1,252	410,646	71
72	07200 Impl. Dev. Charged to Patients				28,178	28,178		28,178	72
73	07300 Drugs Charged to Patients		866,154	866,154		866,154		866,154	73
76	03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		490,081	490,081		490,081		490,081	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	2,198,319	501,094	2,699,413	-55,655	2,643,758	-254,533	2,389,225	88
90	09000 Clinic	9,961	3,803	13,764	55,655	69,419		69,419	90
91	09100 Emergency	946,439	1,672,101	2,618,540		2,618,540	-879,451	1,739,089	91
92	09200 Observation Beds (Non-Distinct Part)								92
	OTHER REIMBURSABLE COST CENTERS								
95	09500 Ambulance Services	629,947	116,716	746,663		746,663		746,663	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)	10,482,197	15,222,454	25,704,651		25,704,651	-2,490,116	23,214,535	118
	NONREIMBURSABLE COST CENTERS								
190	19000 Gift, Flower, Coffee Shop & Canteen								190
192	19200 Physicians' Private Offices	33,540	13,207	46,747		46,747		46,747	192
200	TOTAL (sum of lines 118-199)	10,515,737	15,235,661	25,751,398		25,751,398	-2,490,116	23,261,282	200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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		140,078	1
500	Total reclassifications					140,078	500
	Code Letter - A						
1	RESPIRATORY THERAPY	B	Electrocardiology	69	45,658		1
2			Electroencephalography	70	15,219		2
500	Total reclassifications				60,877		500
	Code Letter - B						
1	INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	1.01		5,599	1
2			Cap Rel Costs-Mvble Equip	2		5,443	2
500	Total reclassifications					11,042	500
	Code Letter - C						
1	OPERATING ROOM	D	Operating Room	50		11,016	1
500	Total reclassifications					11,016	500
	Code Letter - D						
1	RECLASS PORTION OF DIETARY TO CAFE	E	Cafeteria	11	146,596	105,688	1
500	Total reclassifications				146,596	105,688	500
	Code Letter - E						
1	RECLASS IMPLANTABLE DEVICE COST	F	Impl. Dev. Charged to Patient	72		28,178	1
500	Total reclassifications					28,178	500
	Code Letter - F						
1	DIEBETIES EDUCATION	G	Clinic	90	55,655		1
500	Total reclassifications				55,655		500
	Code Letter - G						
1	CNE SALARY EXPENSE	H	Nursing Administration	13	117,500		1
500	Total reclassifications				117,500		500
	Code Letter - H						
	GRAND TOTAL (Increases)				380,628	296,002	

(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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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		140,078	9	
500	Total reclassifications					140,078	1	
	Code letter - A						500	
1	RESPIRATORY THERAPY	B	Respiratory Therapy	65	60,877		1	
2							2	
500	Total reclassifications				60,877		500	
	Code letter - B							
1	INSURANCE EXPENSE	C	Cap Rel Costs-Bldg & Fixt	1		11,042	12	
2							12	
500	Total reclassifications					11,042	2	
	Code letter - C						500	
1	OPERATING ROOM	D	Anesthesiology	53		11,016	1	
500	Total reclassifications					11,016	500	
	Code letter - D							
1	RECLASS PORTION OF DIETARY TO CAFE	E	Dietary	10	146,596	105,688	1	
500	Total reclassifications				146,596	105,688	500	
	Code letter - E							
1	RECLASS IMPLANTABLE DEVICE COST	F	Medical Supplies Charged to P	71		28,178	1	
500	Total reclassifications					28,178	500	
	Code letter - F							
1	DIEBETIES EDUCATION	G	Rural Health Clinic	88	55,655		1	
500	Total reclassifications				55,655		500	
	Code letter - G							
1	CNE SALARY EXPENSE	H	Administrative & General	5	117,500		1	
500	Total reclassifications				117,500		500	
	Code letter - H							
	GRAND TOTAL (Decreases)				380,628	296,002		

(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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	132,111					132,111		1
2	Land Improvements	347,032				1,180	345,852		2
3	Buildings and Fixtures	12,554,850	369,031		369,031		12,923,881		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	6,963,321	809,619		809,619	961,025	6,811,915		6
7	HIT-designated Assets	1,492,130	23,600		23,600		1,515,730		7
8	Subtotal (sum of lines 1-7)	21,489,444	1,202,250		1,202,250	962,205	21,729,489		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	21,489,444	1,202,250		1,202,250	962,205	21,729,489		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	627,019		221,696	37,384			886,099	1	
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT					4,040		4,040	1.01	
2	Cap Rel Costs-Mvble Equip	825,786	110,741					936,527	2	
3	Total (sum of lines 1-2)	1,452,805	110,741	221,696	37,384	4,040		1,826,666	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				Total (sum of cols. 5 through 7)	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs			
*		1	2	3	4	5	6	7	8		
1	Cap Rel Costs-Bldg & Fi	13,401,844		13,401,844	0.616758					1	
1.01	NEW CAP RHC REL COSTS-B				0.000000					1.01	
2	Cap Rel Costs-Mvble Equ	8,327,645		8,327,645	0.383242					2	
3	Total (sum of lines 1-2)	21,729,489		21,729,489	1.000000					3	

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	486,941		140,199	26,342			653,482	1	
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	140,078			5,599	4,040		149,717	1.01	
2	Cap Rel Costs-Mvble Equip	825,786	110,741		5,443			941,970	2	
3	Total (sum of lines 1-2)	1,452,805	110,741	140,199	37,384	4,040		1,745,169	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.)

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	-81,497	Cap Rel Costs-Bldg & Fixt	1	11
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trace, quantity, and time discounts (chapter 8)	B	-246	Administrative & General	5	4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)	A	-3,306	Administrative & General	5	7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-1,394,644			10
11	Sale of scrap, waste, etc. (chapter 23)	B	-241	Administrative & General	5	11
12	Related organization transactions (chapter 10)	Wkst A-8-1				12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-129,603	Cafeteria	11	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients	B	-1,252	Medical Supplies Charged to Patients	71	16
17	Sale of drugs to other than patients					17
18	Sale of medical records and abstracts	B	-2,948	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines	B	-132	Administrative & General	5	20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation					32
33	EKG PHYSICIAN EMPLOYEE BENEFITS	A	-94,212	Employee Benefits Department	4	33
34	MISCELLANEOUS REVENUE	B	-69,496	Administrative & General	5	34
35	PUBLIC RELATIONS	A	-271,147	Administrative & General	5	35
36	LOBBYING EXPENSE	A	-9,708	Administrative & General	5	36
37	CRNA EXPENSE	A	-344,340	Anesthesiology	53	37
38	EMPLOYEE BENEFITS LAB TESTS	A	-1,687	Employee Benefits Department	4	38
39	RHC PHYSICIAN HOSPITAL INCENTIVES	A	-2,500	Rural Health Clinic	88	39
40	PHYSICIAN RECRUITMENT	A	-83,157	Rural Health Clinic	88	40
41						41
42						42
43						43
44						44
45						45
46						46
47						47
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,490,116			50

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1
- (2) Basis for adjustment (see instructions)
 - A. Costs - if cost, including applicable overhead, can be determined
 - B. Amount Received - if cost cannot be determined
- (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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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:

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	30	Adults & Pediatrics AGGREGATE	273,378	273,378						1
2	60	Laboratory AGGREGATE	23,500		23,500					2
3	65	Respiratory Therapy AGGREGATE	2,369	2,369						3
4	69	Electrocardiology AGGREGATE	19,820	19,820						4
5	70	Electroencephalogram AGGREGATE	50,750	50,750						5
6	88	Rural Health Clinic AGGREGATE	168,876	168,876						6
7	91	Emergency AGGREGATE	1,516,034	879,451	636,583					7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,054,727	1,394,644	660,083					200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	30	Adults & Pediatrics AGGREGATE							273,378	1
2	60	Laboratory AGGREGATE								2
3	65	Respiratory Therapy AGGREGATE							2,369	3
4	69	Electrocardiology AGGREGATE							19,820	4
5	70	Electroencephalogram AGGREGATE							50,750	5
6	88	Rural Health Clinic AGGREGATE							168,876	6
7	91	Emergency AGGREGATE							879,451	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,394,644	200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	653,482	653,482					1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	149,717		149,717				1.01
2	Cap Rel Costs-Mvble Equip	941,970			941,970			2
4	Employee Benefits Department	3,398,864				3,398,864		4
5	Administrative & General	3,041,117	285,179		316,398	331,075	3,973,769	5
6	Maintenance & Repairs							6
7	Operation of Plant	695,741	4,936		5,477	75,748	781,902	7
7.01	RHC UTILITY EXPENSE	38,905					38,905	7.01
8	Laundry & Linen Service	88,115					88,115	8
9	Housekeeping	282,365	3,594		3,988	74,557	364,504	9
10	Dietary	105,240	11,510		16,867	20,038	153,655	10
11	Cafeteria	122,681	3,693			48,035	174,409	11
12	Maintenance of Personnel							12
13	Nursing Administration	624,546	3,090		3,428	186,905	817,969	13
14	Central Services & Supply	47,261	5,367		5,955	9,481	68,064	14
15	Pharmacy	239,148	5,170		5,736	64,172	314,226	15
16	Medical Records & Library	399,074	40,511		44,946	97,014	581,545	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	1,225,975	75,187		83,419	459,459	1,844,040	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	996,120	50,063		55,544	255,401	1,357,128	50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,090,994	36,978		41,026	132,997	1,301,995	54
60	Laboratory	1,505,805	14,747		16,361	152,180	1,689,093	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	296,685	4,136		4,589	79,790	385,200	65
66	Physical Therapy	456,206		36,824	53,359	134,466	680,855	66
69	Electrocardiology	59,836	4,136		4,589	21,455	90,016	69
70	Electroencephalography	15,233	4,124		4,575	4,987	28,919	70
71	Medical Supplies Charged to Patients	410,646					410,646	71
72	Impl. Dev. Charged to Patients	28,178					28,178	72
73	Drugs Charged to Patients	866,154					866,154	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	490,081	31,783		35,263		557,127	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	2,389,225		102,431	148,427	702,081	3,342,164	88
90	Clinic	69,419				21,500	90,919	90
91	Emergency	1,739,089	34,405		38,172	310,119	2,121,785	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	746,663	15,313		16,990	206,414	985,380	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	23,214,535	633,922	139,255	905,109	3,387,874	23,136,662	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		3,311		3,674		6,985	190
192	Physicians' Private Offices	46,747	16,249	10,462	33,187	10,990	117,635	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	23,261,282	653,482	149,717	941,970	3,398,864	23,261,282	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	3,973,769						5
6	Maintenance & Repairs							6
7	Operation of Plant	161,094	942,996					7
7.01	RHC UTILITY EXPENSE	8,016		46,921				7.01
8	Laundry & Linen Service	18,154			106,269			8
9	Housekeeping	75,098	9,328			448,930		9
10	Dietary	31,657	29,869			12,290	227,471	10
11	Cafeteria	35,933	9,584					11
12	Maintenance of Personnel							12
13	Nursing Administration	168,525	8,018			2,498		13
14	Central Services & Supply	14,023	13,928			4,339		14
15	Pharmacy	64,739	13,417			4,180		15
16	Medical Records & Library	119,815	105,132			32,750		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	379,924	195,122		106,269	60,783	227,471	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	279,606	129,922			40,473		50
53	Anesthesiology							53
54	Radiology-Diagnostic	268,247	95,964			29,894		54
60	Laboratory	348,000	38,271			11,922		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	79,362	10,734			3,344		65
66	Physical Therapy	140,275		11,540		38,880		66
69	Electrocardiology	18,546	10,734			3,344		69
70	Electroencephalography	5,958	10,702			3,334		70
71	Medical Supplies Charged to Patients	84,605						71
72	Impl. Dev. Charged to Patients	5,805						72
73	Drugs Charged to Patients	178,452						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	114,784	82,483			25,695		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	688,581		32,102		108,151		88
90	Clinic	18,732						90
91	Emergency	437,147	89,287			27,814		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	203,016	39,740			12,380		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)	3,948,094	892,235	43,642	106,269	422,071	227,471	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,439	8,593			2,677		190
192	Physicians' Private Offices	24,236	42,168	3,279		24,182		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,973,769	942,996	46,921	106,269	448,930	227,471	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SUBTOTAL	
		11	13	14	15	16	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	RHC UTILITY EXPENSE							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	219,926						11
12	Maintenance of Personnel							12
13	Nursing Administration	14,426	1,011,436					13
14	Central Services & Supply	732	6,245	107,331				14
15	Pharmacy	4,953		902	402,417			15
16	Medical Records & Library	7,488				846,730		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	35,462	243,124	2,462		45,137	3,139,794	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,712	168,244	30,815		43,065	2,068,965	50
53	Anesthesiology							53
54	Radiology-Diagnostic	10,265	87,611	6,836		177,155	1,977,967	54
60	Laboratory	11,745	100,247	45,448		173,344	2,418,070	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	6,158	65,702	1,792		13,290	565,582	65
66	Physical Therapy	10,378		655		40,194	922,777	66
69	Electrocardiology	1,656		3		11,470	135,769	69
70	Electroencephalography	385				6,827	56,125	70
71	Medical Supplies Charged to Patients			8,468		47,383	551,102	71
72	Impl. Dev. Charged to Patients			2,634		2,148	38,765	72
73	Drugs Charged to Patients				402,417	117,378	1,564,401	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					15,350	795,439	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	54,193		2,250		44,944	4,272,385	88
90	Clinic	1,659				1,009	112,319	90
91	Emergency	23,935	204,289	4,254		78,089	2,986,600	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	15,931	135,974	812		29,947	1,423,180	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)	219,078	1,011,436	107,331	402,417	846,730	23,029,240	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						19,694	190
192	Physicians' Private Offices	848					212,348	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	219,926	1,011,436	107,331	402,417	846,730	23,261,282	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		25	26		
	GENERAL SERVICE COST CENTERS				
1	Cap Rel Costs-Bldg & Fixt				1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT				1.01
2	Cap Rel Costs-Mvble Equip				2
4	Employee Benefits Department				4
5	Administrative & General				5
6	Maintenance & Repairs				6
7	Operation of Plant				7
7.01	RHC UTILITY EXPENSE				7.01
8	Laundry & Linen Service				8
9	Housekeeping				9
10	Dietary				10
11	Cafeteria				11
12	Maintenance of Personnel				12
13	Nursing Administration				13
14	Central Services & Supply				14
15	Pharmacy				15
16	Medical Records & Library				16
17	Social Service				17
19	Nonphysician Anesthetists				19
20	Nursing School				20
21	I&R Services-Salary & Fringes Apprvd				21
22	I&R Services-Other Prgm Costs Apprvd				22
23	Paramed Ed Prgm-(specify)				23
	INPATIENT ROUTINE SERV COST CENTERS				
30	Adults & Pediatrics		3,139,794		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room		2,068,965		50
53	Anesthesiology				53
54	Radiology-Diagnostic		1,977,967		54
60	Laboratory		2,418,070		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy		565,582		65
66	Physical Therapy		922,777		66
69	Electrocardiology		135,769		69
70	Electroencephalography		56,125		70
71	Medical Supplies Charged to Patients		551,102		71
72	Impl. Dev. Charged to Patients		38,765		72
73	Drugs Charged to Patients		1,564,401		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		795,439		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		4,272,385		88
90	Clinic		112,319		90
91	Emergency		2,986,600		91
92	Observation Beds (Non-Distinct Part)				92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services		1,423,180		95
99.10	CORF				99.10
99.20	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	OUTPATIENT SPEECH PATHOLOGY				99.40
	SPECIAL PURPOSE COST CENTERS				
118	SUBTOTALS (sum of lines 1-117)		23,029,240		118
	NONREIMBURSABLE COST CENTERS				
190	Gift, Flower, Coffee Shop & Canteen		19,694		190
192	Physicians' Private Offices		212,348		192
200	Cross Foot Adjustments				200
201	Negative Cost Centers				201
202	TOTAL (sum of lines 118-201)		23,261,282		202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	NEW RHC BUILDING FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	
		0	1	1.01	2	2A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		285,179		316,398	601,577	601,577	5
6	Maintenance & Repairs							6
7	Operation of Plant		4,936		5,477	10,413	24,388	7
7.01	RHC UTILITY EXPENSE						4,213	7.01
8	Laundry & Linen Service						2,748	8
9	Housekeeping		3,594		3,988	7,582	11,369	9
10	Dietary		11,510		16,867	28,377	4,792	10
11	Cafeteria		3,693			3,693	5,440	11
12	Maintenance of Personnel							12
13	Nursing Administration		3,090		3,428	6,518	25,512	13
14	Central Services & Supply		5,367		5,955	11,322	2,123	14
15	Pharmacy		5,170		5,736	10,906	9,801	15
16	Medical Records & Library		40,511		44,946	85,457	18,138	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		75,187		83,419	158,606	57,516	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		50,063		55,544	105,607	42,329	50
53	Anesthesiology							53
54	Radiology-Diagnostic		36,978		41,026	78,004	40,609	54
60	Laboratory		14,747		16,361	31,108	52,683	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		4,136		4,589	8,725	12,014	65
66	Physical Therapy			36,824	53,359	90,183	21,236	66
69	Electrocardiology		4,136		4,589	8,725	2,808	69
70	Electroencephalography		4,124		4,575	8,699	902	70
71	Medical Supplies Charged to Patients						12,808	71
72	Impl. Dev. Charged to Patients						879	72
73	Drugs Charged to Patients						27,015	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		31,783		35,263	67,046	17,377	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			102,431	148,427	250,858	104,242	88
90	Clinic						2,836	90
91	Emergency		34,405		38,172	72,577	66,178	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		15,313		16,990	32,303	30,734	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)		633,922	139,255	905,109	1,678,286	597,690	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		3,311		3,674	6,985	218	190
192	Physicians' Private Offices		16,249	10,462	33,187	59,898	3,669	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		653,482	149,717	941,970	1,745,169	601,577	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	34,801						7
7.01	RHC UTILITY EXPENSE		1,213					7.01
8	Laundry & Linen Service			2,748				8
9	Housekeeping	344			19,295			9
10	Dietary	1,102			528	34,799		10
11	Cafeteria	354					9,487	11
12	Maintenance of Personnel							12
13	Nursing Administration	296			107		622	13
14	Central Services & Supply	514			186		32	14
15	Pharmacy	495			180		214	15
16	Medical Records & Library	3,880			1,408		323	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	7,201		2,748	2,612	34,799	1,530	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,795			1,740		850	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,542			1,285		443	54
60	Laboratory	1,412			512		507	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	396			144		266	65
66	Physical Therapy		298		1,671		448	66
69	Electrocardiology	396			144		71	69
70	Electroencephalography	395			143		17	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,044			1,104			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		830		4,650		2,335	88
90	Clinic						72	90
91	Emergency	3,295			1,195		1,033	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,467			532		687	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)	32,928	1,128	2,748	18,141	34,799	9,450	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	317			115			190
192	Physicians' Private Offices	1,556	85		1,039		37	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	34,801	1,213	2,748	19,295	34,799	9,487	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	33,055						13
14	Central Services & Supply	204	14,381					14
15	Pharmacy		121	21,717				15
16	Medical Records & Library				109,206			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	7,947	330		5,822	279,111		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,498	4,129		5,554	170,502		50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,863	916		22,847	150,509		54
60	Laboratory	3,276	6,089		22,357	117,944		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,147	240		1,714	25,646		65
66	Physical Therapy		88		5,184	119,108		66
69	Electrocardiology				1,479	13,623		69
70	Electroencephalography				881	11,037		70
71	Medical Supplies Charged to Patients		1,135		6,111	20,054		71
72	Impl. Dev. Charged to Patients		353		277	1,509		72
73	Drugs Charged to Patients				21,717	15,139	63,871	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					1,980	90,551	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		301		5,797	369,013		88
90	Clinic				130	3,038		90
91	Emergency	6,676	570		10,072	161,596		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	4,444	109		3,862	74,138		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)	33,055	14,381	21,717	109,206	1,671,250		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					7,635		190
192	Physicians' Private Offices					66,284		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	33,055	14,381	21,717	109,206	1,745,169		202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	279,111					30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	170,502					50
53	Anesthesiology						53
54	Radiology-Diagnostic	150,509					54
60	Laboratory	117,944					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	25,646					65
66	Physical Therapy	119,108					66
69	Electrocardiology	13,623					69
70	Electroencephalography	11,037					70
71	Medical Supplies Charged to Patients	20,054					71
72	Impl. Dev. Charged to Patients	1,509					72
73	Drugs Charged to Patients	63,871					73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	90,551					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	369,013					88
90	Clinic	3,038					90
91	Emergency	161,596					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	74,138					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)	1,671,250					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	7,635					190
192	Physicians' Private Offices	66,284					192
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	1,745,169					202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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			68,972				2
4	Employee Benefits Department				10,372,871			4
5	Administrative & General	23,167		23,167	1,010,394	-3,973,769	19,287,513	5
6	Maintenance & Repairs							6
7	Operation of Plant	401		401	231,172		781,902	7
7.01	RHC UTILITY EXPENSE						38,905	7.01
8	Laundry & Linen Service						88,115	8
9	Housekeeping	292		292	227,537		364,504	9
10	Dietary	935		1,235	61,153		153,655	10
11	Cafeteria	300			146,596		174,409	11
12	Maintenance of Personnel							12
13	Nursing Administration	251		251	570,409		817,969	13
14	Central Services & Supply	436		436	28,934		68,064	14
15	Pharmacy	420		420	195,845		314,226	15
16	Medical Records & Library	3,291		3,291	296,072		581,545	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	1,402,206		1,844,040	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067		4,067	779,449		1,357,128	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004		3,004	405,889		1,301,995	54
60	Laboratory	1,198		1,198	464,431		1,689,093	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336		336	243,509		385,200	65
66	Physical Therapy		3,907	3,907	410,372		680,855	66
69	Electrocardiology	336		336	65,478		90,016	69
70	Electroencephalography	335		335	15,219		28,919	70
71	Medical Supplies Charged to Patients						410,646	71
72	Impl. Dev. Charged to Patients						28,178	72
73	Drugs Charged to Patients						866,154	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582		2,582			557,127	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	2,142,664		3,342,164	88
90	Clinic				65,616		90,919	90
91	Emergency	2,795		2,795	946,439		2,121,785	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244		1,244	629,947		985,380	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	66,273	10,339,331	-3,973,769	19,162,893	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269		269			6,985	190
192	Physicians' Private Offices	1,320	1,110	2,430	33,540		117,635	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	653,482	149,717	941,970	3,398,864		3,973,769	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.309643	9.425055	13.657281	0.327669		0.206028	203
204	Cost to be allocated (Per Wkst. B, Part II)						601,577	204
205	Unit Cost Multiplier (Wkst. B, Part II)						0.031190	205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	RHC UTILITY EXPENSE SQUARE FEET	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	
		7	7.01	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	29,519						7
7.01	RHC UTILITY EXPENSE		15,885					7.01
8	Laundry & Linen Service			3,276				8
9	Housekeeping	292			45,112			9
10	Dietary	935			1,235	3,276		10
11	Cafeteria	300					8,696,019	11
12	Maintenance of Personnel							12
13	Nursing Administration	251			251		570,409	13
14	Central Services & Supply	436			436		28,934	14
15	Pharmacy	420			420		195,845	15
16	Medical Records & Library	3,291			3,291		296,072	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		3,276	6,108	3,276	1,402,206	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067			4,067		779,449	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004			3,004		405,889	54
60	Laboratory	1,198			1,198		464,431	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336			336		243,509	65
66	Physical Therapy		3,907		3,907		410,372	66
69	Electrocardiology	336			336		65,478	69
70	Electroencephalography	335			335		15,219	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		2,142,664	88
90	Clinic						65,616	90
91	Emergency	2,795			2,795		946,439	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244			1,244		629,947	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	3,276	42,413	3,276	8,662,479	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269			269			190
192	Physicians' Private Offices	1,320	1,110		2,430		33,540	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	942,996	46,921	106,269	448,930	227,471	219,926	202
203	Unit Cost Multiplier (Wkst. B, Part I)	31.945391	2.953793	32.438645	9.951454	69.435592	0.025290	203
204	Cost to be allocated (Per Wkst. B, Part II)	34,801	1,213	2,748	19,295	34,799	9,487	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.178936	0.076361	0.838828	0.427713	10.622405	0.001091	205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

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

GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt				1	
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT				1.01	
2	Cap Rel Costs-Mvble Equip				2	
4	Employee Benefits Department				4	
5	Administrative & General				5	
6	Maintenance & Repairs				6	
7	Operation of Plant				7	
7.01	RHC UTILITY EXPENSE				7.01	
8	Laundry & Linen Service				8	
9	Housekeeping				9	
10	Dietary				10	
11	Cafeteria				11	
12	Maintenance of Personnel				12	
13	Nursing Administration	4,685,831			13	
14	Central Services & Supply	28,933	1,148,401		14	
15	Pharmacy		9,651	503,454	15	
16	Medical Records & Library			56,820,463	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	1,126,356	26,342	3,028,944	30	
ANCILLARY SERVICE COST CENTERS						
50	Operating Room	779,450	329,705	2,889,882	50	
53	Anesthesiology				53	
54	Radiology-Diagnostic	405,889	73,140	11,888,589	54	
60	Laboratory	464,431	486,292	11,632,276	60	
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30	
65	Respiratory Therapy	304,385	19,175	891,804	65	
66	Physical Therapy		7,007	2,697,252	66	
69	Electrocardiology		30	769,676	69	
70	Electroencephalography			458,146	70	
71	Medical Supplies Charged to Patients		90,606	3,179,631	71	
72	Impl. Dev. Charged to Patients		28,178	144,138	72	
73	Drugs Charged to Patients			503,454	73	
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			7,876,678	76	
76.97	CARDIAC REHABILITATION			1,030,031	76.97	
76.98	HYPERBARIC OXYGEN THERAPY				76.98	
76.99	LITHOTRIPSY				76.99	
OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic		24,069	3,015,975	88	
90	Clinic			67,685	90	
91	Emergency	946,440	45,521	5,240,147	91	
92	Observation Beds (Non-Distinct Part)				92	
OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	629,947	8,685	2,009,609	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)	4,685,831	1,148,401	503,454	56,820,463	118
NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen				190	
192	Physicians' Private Offices				192	
200	Cross foot adjustments				200	
201	Negative cost centers				201	
202	Cost to be allocated (Per Wkst. B, Part I)	1,011,436	107,331	402,417	846,730	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.215850	0.093461	0.799312	0.014902	203
204	Cost to be allocated (Per Wkst. B, Part II)	33,055	14,381	21,717	109,206	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.007054	0.012523	0.043136	0.001922	205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		PART	LINE NO.		
	1	2	3	4	

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,139,794		3,139,794			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,068,965		2,068,965			50
53	Anesthesiology						53
54	Radiology-Diagnostic	1,977,967		1,977,967			54
60	Laboratory	2,418,070		2,418,070			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	565,582		565,582			65
66	Physical Therapy	922,777		922,777			66
69	Electrocardiology	135,769		135,769			69
70	Electroencephalography	56,125		56,125			70
71	Medical Supplies Charged to Patients	551,102		551,102			71
72	Impl. Dev. Charged to Patients	38,765		38,765			72
73	Drugs Charged to Patients	1,564,401		1,564,401			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	795,439		795,439			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	4,272,385		4,272,385			88
90	Clinic	112,319		112,319			90
91	Emergency	2,986,600		2,986,600			91
92	Observation Beds (Non-Distinct Part)	94,781		94,781			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,423,180		1,423,180			95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	23,124,021		23,124,021			200
201	Less Observation Beds	94,781		94,781			201
202	Total (line 200 minus line 201)	23,029,240		23,029,240			202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 SERVICE COST CENTERS							
30	Adults & Pediatrics	2,601,286		2,601,286				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	516,883	2,372,999	2,889,882	0.715934			50
53	Anesthesiology							53
54	Radiology-Diagnostic	823,441	11,065,148	11,888,589	0.166375			54
60	Laboratory	1,867,849	9,764,427	11,632,276	0.207876			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	669,579	222,225	891,804	0.634200			65
66	Physical Therapy	550,255	2,146,997	2,697,252	0.342117			66
69	Electrocardiology	69,190	700,486	769,676	0.176398			69
70	Electroencephalography	3,917	454,229	458,146	0.122505			70
71	Medical Supplies Charged to Patients	1,631,013	1,548,618	3,179,631	0.173323			71
72	Impl. Dev. Charged to Patients	26,905	117,233	144,138	0.268944			72
73	Drugs Charged to Patients	3,292,878	4,583,800	7,876,678	0.198612			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1,030,031	1,030,031	0.772248			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		3,015,975	3,015,975				88
90	Clinic		67,685	67,685	1.659437			90
91	Emergency	120,175	5,119,972	5,240,147	0.569946			91
92	Observation Beds (Non-Distinct Part)		427,658	427,658	0.221628			92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		2,009,609	2,009,609	0.708188			95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	12,173,371	44,647,092	56,820,463				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	12,173,371	44,647,092	56,820,463				202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1351

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable Title XVIII, Part B IPF SNF Swing Bed NF
 Boxes: Title XIX - O/P IRF NF ICF/MR

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			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	0.715934		1,043,669			747,198		50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.166375		3,974,960			661,334		54
60	Laboratory	0.207876		4,279,292			889,562		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.634200		85,767			54,393		65
66	Physical Therapy	0.342117		643,983			220,318		66
69	Electrocardiology	0.176398		352,856			62,243		69
70	Electroencephalography	0.122505		152,403			18,670		70
71	Medical Supplies Charged to Patients	0.173323		570,976			98,963		71
72	Impl. Dev. Charged to Patients	0.268944		84,141			22,629		72
73	Drugs Charged to Patients	0.198612		1,605,475			318,867		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.772248		993,603			767,308		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	1.659437		55,692			92,417		90
91	Emergency	0.569946		1,694,909			966,007		91
92	Observation Beds (Non-Distinct Part)	0.221628		97,056			21,510		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.708188							95
200	Subtotal (see instructions)			15,634,782			4,941,419		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			15,634,782			4,941,419		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z351

WORKSHEET D
PART V

Check Title V - O/P Hospital SUB (Other) Swing Bed SNF
 Applicable 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.)	
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.715934						50
53	Anesthesiology							53
54	Radiology-Diagnostic	0.166375						54
60	Laboratory	0.207876						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.634200						65
66	Physical Therapy	0.342117						66
69	Electrocardiology	0.176398						69
70	Electroencephalography	0.122505						70
71	Medical Supplies Charged to Patients	0.173323						71
72	Impl. Dev. Charged to Patients	0.268944						72
73	Drugs Charged to Patients	0.198612						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.772248						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	1.659437						90
91	Emergency	0.569946						91
92	Observation Beds (Non-Distinct Part)	0.221628						92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	0.708188						95
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PART I

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 I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,439	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,410	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)	3,276	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	857	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)	172	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,280	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)	857	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)	172	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	135.00	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	139.00	20
21	Total general inpatient routine service cost (see instructions)	3,139,794	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)	727,832	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,411,962	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,411,962	37

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					707.32	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,612,690	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,612,690	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,528,579	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					3,141,269	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise 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)					606,173	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					121,659	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					727,832	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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

87	Total observation bed days (see instructions)					134	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					707.32	88
89	Observation bed cost (line 87 x line 88) (see instructions)					94,781	89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	279,111	2,411,962	0.115719	94,781	10,968	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1351

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	Adults & Pediatrics		1,864,862		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.715934	464,137	332,291	50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.166375	414,199	68,912	54
60	Laboratory	0.207876	1,133,178	235,561	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.634200	404,147	256,310	65
66	Physical Therapy	0.342117	229,589	78,546	66
69	Electrocardiology	0.176398	60,983	10,757	69
70	Electroencephalography	0.122505	3,673	450	70
71	Medical Supplies Charged to Patients	0.173323	1,028,217	178,214	71
72	Impl. Dev. Charged to Patients	0.268944	13,289	3,574	72
73	Drugs Charged to Patients	0.198612	1,828,055	363,074	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.772248			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	1.659437			90
91	Emergency	0.569946	1,562	890	91
92	Observation Beds (Non-Distinct Part)	0.221628			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		5,581,029	1,528,579	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,581,029		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.715934			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.166375	92,614	15,409	54
60	Laboratory	0.207876	325,472	67,658	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.634200	186,570	118,323	65
66	Physical Therapy	0.342117	294,549	100,770	66
69	Electrocardiology	0.176398	7,251	1,279	69
70	Electroencephalography	0.122505			70
71	Medical Supplies Charged to Patients	0.173323	232,456	40,290	71
72	Impl. Dev. Charged to Patients	0.268944			72
73	Drugs Charged to Patients	0.198612	741,371	147,245	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.772248			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	1.659437			90
91	Emergency	0.569946	1,180	673	91
92	Observation Beds (Non-Distinct Part)	0.221628			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		1,881,463	491,647	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,881,463		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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)	4,941,419		1
2	Medical and other services reimbursed under OPPS (see instructions)			2
3	PPS payments			3
4	Outlier payment (see instructions)			4
5	Enter the hospital specific payment to cost ratio (see instructions)			5
6	Line 2 times line 5			6
7	Sum of line 3 and line 4 divided by line 6			7
8	Transitional corridor payment (see instructions)			8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			9
10	Organ acquisition			10
11	Total cost (sum of lines 1 and 10) (see instructions)	4,941,419		11
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
12	Ancillary service charges			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)			13
14	Total reasonable charges (sum of lines 12 and 13)			14
	CUSTOMARY CHARGES			
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis			15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)			17
18	Total customary charges (see instructions)			18
19	Excess of customary charges over 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)	4,990,833		21
22	Interns and residents (see instructions)			22
23	Cost of physicians' services in a teaching hospital (see instructions)			23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance (see instructions)	43,665		25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,286,567		26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,660,601		27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)			29
30	Subtotal (sum of lines 27 through 29)	2,660,601		30
31	Primary payer payments	135		31
32	Subtotal (line 30 minus line 31)	2,660,466		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)	390,967		34
35	Adjusted reimbursable bad debts (see instructions)	297,135		35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	356,967		36
37	Subtotal (see instructions)	2,957,601		37
38	MSP-LCC reconciliation amount from PS&R			38
39	Other adjustments (specify) (see instructions)			39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
40	Subtotal (see instructions)	2,957,601		40
40.01	Sequestration adjustment (see instructions)	59,152		40.01
41	Interim payments	3,207,979		41
42	Tentative settlement (for contractors use only)			42
43	Balance due provider/program (see instructions)	-309,530		43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)			90
91	Outlier reconciliation adjustment amount (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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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		2,345,092		3,143,760	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	11/18/2014 72,114	08/28/2014	44,955	3.01
	.02	02/19/2015 335,232	11/18/2014	20,800	3.02
	Program to				3.03
	Provider				3.04
					3.05
					3.06
					3.07
					3.08
					3.09
					3.10
	.50	08/28/2014 146,302	02/19/2015	1,536	3.50
					3.51
	Provider to				3.52
	Provider				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	261,044		64,219	3.99
4 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,606,136		3,207,979	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
	Program to				5.03
	Provider				5.04
					5.05
					5.06
					5.07
					5.08
					5.09
					5.10
	.50				5.50
					5.51
	Provider to				5.52
	Provider				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)					7
8 Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 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		1,172,947			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				3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50	08/28/2014	7,503		3.50
		.51	11/18/2014	1,791		3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		-9,294		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			1,163,653		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
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) 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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	956	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	2,280	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	66	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	3,276	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	56,820,463	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,493,945	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	699,182	7
8	Calculation of the HIT incentive payment (see instructions)	654,085	8
9	Sequestration adjustment amount (see instructions)	13,082	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	641,003	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)	641,003	32

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z351

WORKSHEET E-2

Check Title V Swing Bed - SNF
 Applicable 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)	735,110		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 5 and 7, line 202 for Part B) (For CAH, see instructions)	496,563		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,029		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,231,673		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,231,673		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,231,673		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	14,975		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,216,698		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	1,216,698		19
19.01	Sequestration adjustment (see instructions)	24,334		19.01
20	Interim payments	1,163,653		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	28,711		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, §115.2			23

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

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

1	Inpatient services	3,141,269	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	3,141,269	4
5	Primary payer payments		5
6	Total cost (line 4 less line 5) (see instructions)	3,172,682	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	3,172,682	19
20	Deductibles (exclude professional component)	427,868	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,744,814	22
23	Coinsurance	5,674	23
24	Subtotal (line 22 minus line 23)	2,739,140	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	85,551	25
26	Adjusted reimbursable bad debts (see instructions)	65,019	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	80,038	27
28	Subtotal (sum of lines 24 and 26)	2,804,159	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,804,159	30
30.01	Sequestration adjustment (see instructions)	56,083	30.01
31	Interim payments	2,606,136	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	141,940	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4
CURRENT ASSETS					
1	Cash on hand and in banks	1,585,845			1
2	Temporary investments	4,051,523			2
3	Notes receivable				3
4	Accounts receivable	4,330,640			4
5	Other receivables	170,492			5
6	Allowances for uncollectible notes and accounts receivable				6
7	Inventory	213,964			7
8	Prepaid expenses	386,486			8
9	Other current assets				9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	10,738,950			11
FIXED ASSETS					
12	Land	132,111			12
13	Land improvements	345,852			13
14	Accumulated depreciation	-283,410			14
15	Buildings	12,923,882			15
16	Accumulated depreciation	-8,685,252			16
17	Leasehold improvements				17
18	Accumulated depreciation				18
19	Fixed equipment	7,074,533			19
20	Accumulated depreciation	-5,491,618			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	1,515,730			27
28	Accumulated depreciation	-1,104,684			28
29	Minor equipment-nondepreciable				29
30	Total fixed assets (sum of lines 12-29)	6,427,144			30
OTHER ASSETS					
31	Investments				31
32	Deposits on leases				32
33	Due from owners/officers				33
34	Other assets	4,473,901			34
35	Total other assets (sum of lines 31-34)	4,473,901			35
36	Total assets (sum of lines 11, 30 and 35)	21,639,995			36
Liabilities and Fund Balances (Omit Cents)					
		General Fund 1	Specific Purpose Fund 2	Endowment Fund 3	Plant Fund 4
CURRENT LIABILITIES					
37	Accounts payable	1,349,759			37
38	Salaries, wages and fees payable	727,287			38
39	Payroll taxes payable				39
40	Notes and loans payable (short term)				40
41	Deferred income				41
42	Accelerated payments				42
43	Due to other funds				43
44	Other current liabilities	231,261			44
45	Total current liabilities (sum of lines 37 thru 44)	2,308,307			45
LONG TERM LIABILITIES					
46	Mortgage payable				46
47	Notes payable	3,424,494			47
48	Unsecured loans				48
49	Other long term liabilities				49
50	Total long term liabilities (sum of lines 46 thru 49)	3,424,494			50
51	Total liabilities (sum of lines 45 and 50)	5,732,801			51
CAPITAL ACCOUNTS					
52	General fund balance	15,907,194			52
53	Specific purpose fund				53
54	Donor created - endowment fund balance - restricted				54
55	Donor created - endowment fund balance - unrestricted				55
56	Governing body created - endowment fund balance				56
57	Plant fund balance - invested in plant				57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion				58
59	Total fund balances (sum of lines 52 thru 58)	15,907,194			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	21,639,995			60

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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		15,602,229			1
2	Net income (loss) (from Worksheet G-3, line 29)		304,966			2
3	Total (sum of line 1 and line 2)		15,907,195			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		15,907,195			11
12	Deductions (debit adjustments) (specify)	1				12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		1			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		15,907,194			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	2,925,879		2,925,879	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)	2,925,879		2,925,879	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)	2,925,879		2,925,879	17
18	Ancillary services	9,911,223		9,911,223	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)		43,678,971	43,678,971	20
20.01	RHC II		3,384,234	3,384,234	20.01
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance		2,009,609	2,009,609	23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		78,818	78,818	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	12,837,102	49,151,632	61,988,734	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		25,751,398	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			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)		25,751,398	43

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	61,988,734	1
2	Less contractual allowances and discounts on patients' accounts	36,705,840	2
3	Net patient revenues (line 1 minus line 2)	25,282,894	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	25,751,398	4
5	Net income from service to patients (line 3 minus line 4)	-468,504	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	122,317	6
7	Income from investments	90,129	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	129,603	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	2,948	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospitial space		22
23	Governmental appropriations		23
24	Other (TAX REVENUE)	206,208	24
24.01	Other (RENTAL INCOME)	53,764	24.01
24.02	Other (MISCELLANEOUS INCOME)	71,368	24.02
24.03	Other (GRANT INCOME)	80,957	24.03
24.04	Other (EHR INCENTIVE)	115,960	24.04
25	Total other income (sum of lines 6-24)	873,254	25
26	Total (line 5 plus line 25)	404,750	26
27	Other expenses (GAIN/(LOSS) ON DISPOSAL)	99,784	27
28	Total other expenses (sum of line 27 and subscripts)	99,784	28
29	Net income (or loss) for the period (line 26 minus line 28)	304,966	29

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 SERVICE COST CENTERS						
30	Adults & Pediatrics						30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
53	Anesthesiology						53
54	Radiology-Diagnostic						54
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic						88
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

COMPONENT CCN: 14-3458

WORKSHEET M-1

Check applicable box: RHC I 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	789,441	789,441		789,441	-171,376	618,065	1	
2	Physician Assistant							2	
3	Nurse Practitioner	543,211	543,211		543,211		543,211	3	
4	Visiting Nurse							4	
5	Other Nurse	432,696	432,696		432,696		432,696	5	
6	Clinical Psychologist							6	
7	Clinical Social Worker							7	
8	Laboratory Technician							8	
9	Other Facility Health Care Staff Costs	12,385	12,385		12,385		12,385	9	
10	Subtotal (sum of lines 1 through 9)	1,777,733	1,777,733		1,777,733	-171,376	1,606,357	10	
COSTS UNDER AGREEMENT									
11	Physician Services Under Agreement		172,332	172,332	172,332		172,332	11	
12	Physician Supervision Under Agreement							12	
13	Other Costs Under Agreement		85,921	85,921	85,921		85,921	13	
14	Subtotal (sum of lines 11 through 13)		258,253	258,253	258,253		258,253	14	
OTHER HEALTH CARE COSTS									
15	Medical Supplies		27,660	27,660	27,660		27,660	15	
16	Transportation (Health Care Staff)							16	
17	Depreciation-Medical Equipment							17	
18	Professional Liability Insurance		43,411	43,411	43,411		43,411	18	
19	Other Health Care Costs		171,770	171,770	171,770	-83,157	88,613	19	
20	Allowable GME Costs							20	
21	Subtotal (sum of lines 15 through 20)		242,841	242,841	242,841	-83,157	159,684	21	
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,777,733	501,094	2,278,827	2,278,827	-254,533	2,024,294	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 through 27)							28	
FACILITY OVERHEAD									
29	Facility Costs	420,586		420,586	-55,655	364,931	364,931	29	
30	Administrative Costs							30	
31	Total Facility Overhead (sum of lines 29 and 30)	420,586		420,586	-55,655	364,931	364,931	31	
32	Total facility costs (sum of lines 22, 28 and 31)	2,198,319	501,094	2,699,413	-55,655	2,643,758	-254,533	2,389,225	32

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3458

WORKSHEET M-2

Check applicable box: RHC I FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians	2.18	10,405	4,200	9,156		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	3.69	13,561	2,100	7,749		3
4	Subtotal (sum of lines 1 through 3)	5.87	23,966		16,905	23,966	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	5.87	23,966			23,966	8
9	Physician Services Under Agreements		1,733			1,733	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		2,024,294	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)			11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		2,024,294	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)		364,931	14
15	Parent provider overhead allocated to facility (see instructions)		1,883,160	15
16	Total overhead (sum of lines 14 and 15)		2,248,091	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		2,248,091	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		2,248,091	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		4,272,385	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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3458

WORKSHEET M-3

Check applicable boxes: RHC I Title V Title XIX
 FQHC Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	4,272,385	1
2	Cost of vaccines and their administration (from Wkst. M-4, line 15)	13,351	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	4,259,034	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	23,966	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	1,733	5
6	Total adjusted visits (line 4 plus line 5)	25,699	6
7	Adjusted cost per visit (line 3 divided by line 6)	165.73	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)	165.73	165.73	165.73	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		6,437		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,066,804		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,066,804		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)		794,369		16.04
16.05	Total program cost (see instructions)		794,369		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		73,843		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		148,391		19
20	Net Medicare cost excluding vaccines (see instructions)		794,369		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,352		21
22	Total reimbursable Program cost (line 20 plus line 21)		807,721		22
23	Allowable bad debts (see instructions)		49,024		23
23.01	Adjusted reimbursable bad debts (see instructions)		37,258		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		49,024		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		844,979		26
26.01	Sequestration adjustment (see instructions)		16,900		26.01
27	Interim payments		802,326		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		25,753		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3458

WORKSHEET M-4

Check applicable boxes: RHC I Title V Title XIX
 FQHC Title XVIII

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,606,357	1,606,357	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000109	0.000971	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	175	1,560	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	966	3,625	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,141	5,185	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,024,294	2,024,294	6
7	Total overhead (from Wkst. M-2, line 16)	2,248,091	2,248,091	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000564	0.002561	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,268	5,757	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,409	10,942	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	14	125	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	172.07	87.54	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	14	125	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,409	10,943	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		13,351	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		13,352	16

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 I FQHC

			Part B		
DESCRIPTION			mm/dd/yyyy	Amount	
			1	2	
1	Total interim payments paid to provider			809,008	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero				2
3	List separately each retroactive lump sum adjustment 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 zero (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50	08/28/2014	6,682	3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		-6,682	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			802,326	
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 zero (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determine net settlement amount (balance due) 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.

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	Non CMS worksheet CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	----------------------------------	--	--

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	66.86		10.56				77.42	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	Operating Room	16.06	36.11					52.17	50
54	Radiology-Diagnostic	3.48	33.44					36.92	54
60	Laboratory	9.74	36.79					46.53	60
65	Respiratory Therapy	45.32	9.62					54.94	65
66	Physical Therapy	8.51	23.88					32.39	66
69	Electrocardiology	7.92	45.84					53.76	69
70	Electroencephalography	0.80	33.27					34.07	70
71	Medical Supplies Charged to Pat	32.34	17.96					50.30	71
72	Impl. Dev. Charged to Patients	9.22	58.38					67.60	72
73	Drugs Charged to Patients	23.21	20.38					43.59	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI		96.46					96.46	76
90	Clinic		82.28					82.28	90
91	Emergency	0.03	32.34					32.37	91
92	Observation Beds (Non-Distinct		22.69					22.69	92
200	TOTAL CHARGES	10.29	28.84					39.13	200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	Non CMS worksheet CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	----------------------------------	--	--

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	0.78					0.78	54
60	Laboratory	2.80					2.80	60
65	Respiratory Therapy	20.92					20.92	65
66	Physical Therapy	10.92					10.92	66
69	Electrocardiology	0.94					0.94	69
71	Medical Supplies Charged to Pat	7.31					7.31	71
73	Drugs Charged to Patients	9.41					9.41	73
91	Emergency	0.02					0.02	91
200	TOTAL CHARGES	3.47					3.47	200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	Non CMS worksheet CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	----------------------------------	--	--

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	653,482	2.81	-653,482	-6.03			1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	149,717	0.64	-149,717	-1.38			1.01
2	Cap Rel Costs-Mvble Equip	941,970	4.05	-941,970	-8.70			2
3	Other Cap Rel Costs							3
4	Employee Benefits Department	3,398,864	14.61	-3,398,864	-31.39			4
5	Administrative & General	3,041,117	13.07	-3,041,117	-28.09			5
6	Maintenance & Repairs							6
7	Operation of Plant	695,741	2.99	-695,741	-6.43			7
7.01	RHC UTILITY EXPENSE	38,905	0.17	-38,905	-0.36			7.01
8	Laundry & Linen Service	88,115	0.38	-88,115	-0.81			8
9	Housekeeping	282,365	1.21	-282,365	-2.61			9
10	Dietary	105,240	0.45	-105,240	-0.97			10
11	Cafeteria	122,681	0.53	-122,681	-1.13			11
12	Maintenance of Personnel							12
13	Nursing Administration	624,546	2.68	-624,546	-5.77			13
14	Central Services & Supply	47,261	0.20	-47,261	-0.44			14
15	Pharmacy	239,148	1.03	-239,148	-2.21			15
16	Medical Records & Library	399,074	1.72	-399,074	-3.69			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	1,225,975	5.27	1,913,819	17.67	3,139,794	13.50	30
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	996,120	4.28	1,072,845	9.91	2,068,965	8.89	50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,090,994	4.69	886,973	8.19	1,977,967	8.50	54
60	Laboratory	1,505,805	6.47	912,265	8.42	2,418,070	10.40	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	296,685	1.28	268,897	2.48	565,582	2.43	65
66	Physical Therapy	456,206	1.96	466,571	4.31	922,777	3.97	66
69	Electrocardiology	59,836	0.26	75,933	0.70	135,769	0.58	69
70	Electroencephalography	15,233	0.07	40,892	0.38	56,125	0.24	70
71	Medical Supplies Charged to Patients	410,646	1.77	140,456	1.30	551,102	2.37	71
72	Impl. Dev. Charged to Patients	28,178	0.12	10,587	0.10	38,765	0.17	72
73	Drugs Charged to Patients	866,154	3.72	698,247	6.45	1,564,401	6.73	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	490,081	2.11	305,358	2.82	795,439	3.42	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88	Rural Health Clinic	2,389,225	10.27	1,883,160	17.39	4,272,385	18.37	88
90	Clinic	69,419	0.30	42,900	0.40	112,319	0.48	90
91	Emergency	1,739,089	7.48	1,247,511	11.52	2,986,600	12.84	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	746,663	3.21	676,517	6.25	1,423,180	6.12	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			19,694	0.18	19,694	0.08	190
192	Physicians' Private Offices	46,747	0.20	165,601	1.53	212,348	0.91	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL	23,261,282	100.00			23,261,282	100.00	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	Non CMS worksheet CMS-2552-10	Period : From: 03/01/2014 To: 02/28/2015	Run Date: 07/27/2015 Run Time: 14:44 Version: 2015.03 (06/16/2015)
---	----------------------------------	--	--

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 OPSS. (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 OPSS. (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)