

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report Date: 07/29/2019 Time: 13:46 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CLAY COUNTY HOSPITAL (14-1351) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 03/01/2018 and ending 02/28/2019, 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.

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

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

CHIEF FINANCIAL OFFICER
Title

07/29/2019 13:46
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT	TITLE XIX	
		TITLE V	PART A	PART B		
		1	2	3	4	5
1	HOSPITAL		179,678	-90,559		201,845
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF		193,455			5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC			187,833		10
10.01	HEALTH CLINIC - RHC II					10.01
10.02	HEALTH CLINIC - RHC III					10.02
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL		373,133	97,274		201,845

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

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

WORKSHEET S
PARTS I, II & III

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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 911 STACY BURK DRIVE	P.O. Box:			1
2	City: FLORA	State: IL	ZIP Code: 62839-0280	County: CLAY	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
	0	1	2	3	4	5	V	XVIII	XIX	
3	Hospital	CLAY COUNTY HOSPITAL	14-1351	99914	1	12 / 21 / 2005	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	CLAY COUNTY SWING BED	14-Z351	99914		12 / 21 / 2005	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTG									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	CLAY COUNTY MEDICAL CLINIC	14-3458	99914		11 / 29 / 2005	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	LOUISVILLE MEDICAL CLINIC	14-3487	99914		12 / 18 / 2006	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CLAY COUNTY HOSPITAL CLAY CITY CLINI	14-8558	99914		09 / 02 / 2016	N	O	N	15.02
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 / 2018	To: 02 / 28 / 2019		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
----	---	---	--	----

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

	Teaching Hospitals	1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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. Enter in column 4, the direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 through 67. (see instructions)	N			63
----	--	---	--	--	----

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 is yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

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

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			Y		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	N	N	N	109

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	N		111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	142,002			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name:	Contractor's Name:		Contractor's Number:		141	
142	Street:	P.O. Box:				142	
143	City:	State:	ZIP Code:			143	
144	Are provider based physicians' costs included in Worksheet A?				Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.				N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.				N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.				N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.				N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.				N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2016	09 / 30 / 2017	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		1	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see 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

		Y/N	
Bad Debts			
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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/19/2019	Y	06/19/2019	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

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

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

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

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	20	7,300	47,082.00		1,193	156	1,803	1
2	HMO and other (see instructions)						85			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						459		459	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		20	7,300	47,082.00		1,652	156	2,262	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		20	7,300	47,082.00		1,652	156	2,262	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					5,180		21,277	26
26.01	RHC II	88.01								26.01
26.02	RHC III	88.02								26.02
27	Total (sum of lines 14-26)		20							27
28	Observation Bed Days							91	480	28
29	Ambulance Trips						1,228			29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					384	50	536	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)		215.80			384	50	536	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		43.10						26
26.01	RHC II								26.01
26.02	RHC III								26.02
27	Total (sum of lines 14-26)		258.90						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each 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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3458

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

1	Street: 929 STACY BURK DRIVE	1
2	City: FLORA State: IL ZIP Code: 62839 County: CLAY	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS)			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	Y	2	13
14	RHC/FQHC name: CLAY COUNTY HOSPITAL CLIN CCN number: 14-3458			14
14.0	Provider name: LOUISVILLE MEDICAL CLINIC CCN number: 14-3487			14.0
1				1

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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)	0.376959	1
---	--	----------	---

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,894,890	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	13,231,879	6
7	Medicaid cost (line 1 times line 6)	4,987,876	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.	2,092,986	8

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

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

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

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

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

17	Private grants, donations, or endowment income restricted to fundng charity care	153,415	17
18	Government grants, appropriations of transfers for support of hospital operations	573,911	18
19	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,092,986	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	359,702	2,086,376	2,446,078	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	135,593	2,086,376	2,221,969	21
22	Payments received from patients for amounts previously written off as charity care	2,868	14,970	17,838	22
23	Cost of charity care (line 21 minus line 22)	132,725	2,071,406	2,204,131	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	3,209,948	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	181,919	27
27.0	Medicare allowable bad debts for the entire hospital complex (see instructions)	279,876	27.0
1			1
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,930,072	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,202,474	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	3,406,605	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,499,591	31

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	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		599,160	599,160	-159,901	439,259	-14,888	424,371	1
1.01	00101	NEW CAP RHC REL COSTS-BLDG & FIXT		8,204	8,204	189,649	197,853		197,853	1.01
2	00200	Cap Rel Costs-Mvble Equip		709,863	709,863	28,921	738,784	-57,628	681,156	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	195,803	3,678,296	3,874,099		3,874,099	-116,411	3,757,688	4
5	00500	Administrative & General	2,025,596	2,717,563	4,743,159	-58,669	4,684,490	-479,915	4,204,575	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	276,702	538,043	814,745		814,745		814,745	7
7.01	00701	RHC UTILITY EXPENSE		47,696	47,696		47,696		47,696	7.01
8	00800	Laundry & Linen Service		99,708	99,708		99,708		99,708	8
9	00900	Housekeeping	314,502	40,231	354,733		354,733		354,733	9
10	01000	Dietary	324,057	140,912	464,969	-392,244	72,725		72,725	10
11	01100	Cafeteria				392,244	392,244	-142,496	249,748	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	223,851	31,934	255,785		255,785		255,785	13
14	01400	Central Services & Supply	29,445	19,632	49,077		49,077		49,077	14
15	01500	Pharmacy	184,038	252,526	436,564		436,564	-104,738	331,826	15
16	01600	Medical Records & Library	384,287	114,209	498,496		498,496	-9,150	489,346	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	1,465,370	496,203	1,961,573		1,961,573	-378,048	1,583,525	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	369,919	110,844	480,763	9,103	489,866		489,866	50
53	05300	Anesthesiology		255,047	255,047	-9,103	245,944	-245,944		53
54	05400	Radiology-Diagnostic	439,433	820,836	1,260,269		1,260,269		1,260,269	54
60	06000	Laboratory	581,554	1,005,718	1,587,272		1,587,272		1,587,272	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	419,976	55,969	475,945	-83,995	391,950		391,950	65
66	06600	Physical Therapy	522,469	20,461	542,930		542,930		542,930	66
69	06900	Electrocardiology		33,719	33,719	62,996	96,715		96,715	69
70	07000	Electroencephalography				20,999	20,999		20,999	70
71	07100	Medical Supplies Charged to Patients		377,360	377,360	-12,409	364,951	-6,612	358,339	71
72	07200	Impl. Dev. Charged to Patients				12,409	12,409		12,409	72
73	07300	Drugs Charged to Patients		551,597	551,597		551,597	-148,384	403,213	73
76	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		497,507	497,507		497,507		497,507	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	3,065,546	466,061	3,531,607	-54,788	3,476,819	-159,408	3,317,411	88
90	09000	Clinic				54,788	54,788		54,788	90
91	09100	Emergency	782,569	1,127,756	1,910,325		1,910,325		1,910,325	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
95	09500	Ambulance Services	876,299	118,659	994,958		994,958		994,958	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)	12,481,416	14,935,714	27,417,130		27,417,130	-1,863,622	25,553,508	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices		5,564	5,564		5,564		5,564	192
200		TOTAL (sum of lines 118-199)	12,481,416	14,941,278	27,422,694		27,422,694	-1,863,622	25,559,072	200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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		159,901
500	Total reclassifications					159,901
	Code Letter - A					
1	RESPIRATORY THERAPY	B	Electrocardiology	69	62,996	
2			Electroencephalography	70	20,999	
500	Total reclassifications				83,995	
	Code Letter - B					
1	INSURANCE EXPENSE	C	NEW CAP RHC REL COSTS-BLDG &	1.01		29,748
2			Cap Rel Costs-Mvble Equip	2		28,921
500	Total reclassifications					58,669
	Code Letter - C					
1	OPERATING ROOM	D	Operating Room	50		9,103
500	Total reclassifications					9,103
	Code Letter - D					
1	RECLASS PORTION OF DIETARY TO CAFE	E	Cafeteria	11	273,372	118,872
500	Total reclassifications				273,372	118,872
	Code Letter - E					
1	RECLASS IMPLANTABLE DEVICE COST	F	Impl. Dev. Charged to Patient	72		12,409
500	Total reclassifications					12,409
	Code Letter - F					
1	DIEBETIES EDUCATION	G	Clinic	90	54,788	
500	Total reclassifications				54,788	
	Code Letter - G					
	GRAND TOTAL (Increases)				412,155	358,954

(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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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		159,901	9	1
500	Total reclassifications					159,901		500
	Code letter - A							
1	RESPIRATORY THERAPY	B	Respiratory Therapy	65	83,995			1
2								2
500	Total reclassifications				83,995			500
	Code letter - B							
1	INSURANCE EXPENSE	C	Administrative & General	5		58,669	12	1
2							12	2
500	Total reclassifications					58,669		500
	Code letter - C							
1	OPERATING ROOM	D	Anesthesiology	53		9,103		1
500	Total reclassifications					9,103		500
	Code letter - D							
1	RECLASS PORTION OF DIETARY TO CAFE	E	Dietary	10	273,372	118,872		1
500	Total reclassifications				273,372	118,872		500
	Code letter - E							
1	RECLASS IMPLANTABLE DEVICE COST	F	Medical Supplies Charged to P	71		12,409		1
500	Total reclassifications					12,409		500
	Code letter - F							
1	DIEBETIES EDUCATION	G	Rural Health Clinic	88	54,788			1
500	Total reclassifications				54,788			500
	Code letter - G							
	GRAND TOTAL (Decreases)				412,155	358,954		

(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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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	135,111					135,111		1
2	Land Improvements	351,668					351,668		2
3	Buildings and Fixtures	13,269,019	169,310		169,310		13,438,329		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	8,356,692	429,603		429,603	30,250	8,756,045		6
7	HIT-designated Assets	1,573,806					1,573,806		7
8	Subtotal (sum of lines 1-7)	23,686,296	598,913		598,913	30,250	24,254,959		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	23,686,296	598,913		598,913	30,250	24,254,959		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	577,559		21,601				599,160	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT					8,204		8,204	1.01
2	Cap Rel Costs-Mvble Equip	609,960	99,903					709,863	2
3	Total (sum of lines 1-2)	1,187,519	99,903	21,601		8,204		1,317,227	3

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

have been included in Worksheet A, column 2, lines 1 and 2.

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
*										
1	Cap Rel Costs-Bldg & Fi	13,925,107		13,925,107	0.574114					1
1.01	NEW CAP RHC REL COSTS-B				0.000000					1.01
2	Cap Rel Costs-Mvble Equ	10,329,851		10,329,851	0.425886					2
3	Total (sum of lines 1-2)	24,254,958		24,254,958	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	417,658		6,713				424,371	1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	159,901			29,748	8,204		197,853	1.01
2	Cap Rel Costs-Mvble Equip	552,332	99,903		28,921			681,156	2
3	Total (sum of lines 1-2)	1,129,891	99,903	6,713	58,669	8,204		1,303,380	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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-14,888	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)	B	-1,007	Administrative & General	5		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-475,254				10
11	Sale of scrap, waste, etc. (chapter 23)	B					11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-142,496	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-6,612	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-9,150	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines	B	-1,656	Administrative & General	5		20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-57,628	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYSICIAN EMPLOYEE BENEFITS	A	-115,800	Employee Benefits Department	4		33
34	MISCELLANEOUS REVENUE	B	-104,090	Administrative & General	5		34
35	PUBLIC RELATIONS	A	-365,016	Administrative & General	5		35
36	LOBBYING EXPENSE	A	-8,146	Administrative & General	5		36
37	CRNA EXPENSE	A	-245,944	Anesthesiology	53		37
38	EMPLOYEE BENEFITS LAB TESTS	A	-43,620	Employee Benefits Department	4		38
39	RHC PHYSICIAN HOSPITAL INCENTIV	A					39
40	PHYSICIAN RECRUITMENT	A	-62,202	Rural Health Clinic	88		40
41	CLINIC PHYSICIAN HOSPITAL INCENTIV						41
42	PENSION DIFFERENTIAL	A	43,009	Employee Benefits Department	4		42
43	340B EXPENSES	A	-148,384	Drugs Charged to Patients	73		43
44	340B EXPENSES	A	-104,738	Pharmacy	15		44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,863,622				50

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

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

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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	334,384	334,384						1
2	60	Laboratory AGGREGATE	24,000		24,000					2
3	65	Respiratory Therapy AGGREGATE								3
4	69	Electrocardiology AGGREGATE								4
5	70	Electroencephalogram AGGREGATE								5
6	88	Rural Health Clinic AGGREGATE	32,850	32,850						6
7	91	Emergency AGGREGATE	936,000		936,000					7
8	88	Rural Health Clinic AGGREGATE	64,356	64,356						8
9	30	Adults & Pediatrics AGGREGATE	417,164	43,664	373,500					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	1,808,754	475,254	1,333,500					200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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							334,384	1
2	60	Laboratory AGGREGATE								2
3	65	Respiratory Therapy AGGREGATE								3
4	69	Electrocardiology AGGREGATE								4
5	70	Electroencephalogram AGGREGATE								5
6	88	Rural Health Clinic AGGREGATE							32,850	6
7	91	Emergency AGGREGATE								7
8	88	Rural Health Clinic AGGREGATE							64,356	8
9	30	Adults & Pediatrics AGGREGATE							43,664	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							475,254	200

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	NEW RHC BUILDING FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMEN T	SUBTOTAL (cols.0-4)	
		0	1	1.01	2	4	4A	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	424,371	424,371					1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT	197,853		197,853				1.01
2	Cap Rel Costs-Mvble Equip	681,156			681,156			2
4	Employee Benefits Department	3,757,688				3,757,688		4
5	Administrative & General	4,204,575	185,195		215,668	619,551	5,224,989	5
6	Maintenance & Repairs							6
7	Operation of Plant	814,745	3,206		3,733	84,632	906,316	7
7.01	RHC UTILITY EXPENSE	47,696					47,696	7.01
8	Laundry & Linen Service	99,708					99,708	8
9	Housekeeping	354,733	2,334		2,718	96,194	455,979	9
10	Dietary	72,725	7,474		11,497	15,503	107,199	10
11	Cafeteria	249,748	2,398			83,614	335,760	11
12	Maintenance of Personnel							12
13	Nursing Administration	255,785	2,006		2,337	68,467	328,595	13
14	Central Services & Supply	49,077	3,485		4,059	9,006	65,627	14
15	Pharmacy	331,826	3,357		3,910	56,290	395,383	15
16	Medical Records & Library	489,346	26,308		30,637	117,538	663,829	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	1,583,525	48,827		56,862	448,200	2,137,414	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	489,866	32,511		37,861	113,144	673,382	50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,260,269	24,014		27,965	134,405	1,446,653	54
60	Laboratory	1,587,272	9,577		11,153	177,875	1,785,877	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	391,950	2,686		3,128	102,763	500,527	65
66	Physical Therapy	542,930		38,493	36,372	159,803	777,598	66
69	Electrocardiology	96,715	2,686		3,128	19,268	121,797	69
70	Electroencephalography	20,999	2,678		3,119	6,423	33,219	70
71	Medical Supplies Charged to Patients	358,339					358,339	71
72	Impl. Dev. Charged to Patients	12,409					12,409	72
73	Drugs Charged to Patients	403,213					403,213	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	497,507	20,640		24,037		542,184	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	3,317,411		148,424	140,245	920,871	4,526,951	88
90	Clinic	54,788				16,758	71,546	90
91	Emergency	1,910,325	22,343		26,020	239,357	2,198,045	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	994,958	9,944		11,581	268,026	1,284,509	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)	25,553,508	411,669	186,917	656,030	3,757,688	25,504,744	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,150		2,504		4,654	190
192	Physicians' Private Offices	5,564	10,552	10,936	22,622		49,674	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,559,072	424,371	197,853	681,156	3,757,688	25,559,072	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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	5,224,989						5
6	Maintenance & Repairs							6
7	Operation of Plant	232,884	1,139,200					7
7.01	RHC UTILITY EXPENSE	12,256		59,952				7.01
8	Laundry & Linen Service	25,621			125,329			8
9	Housekeeping	117,167	11,269			584,415		9
10	Dietary	27,546	36,084			11,082	181,911	10
11	Cafeteria	86,276	11,578			3,556		11
12	Maintenance of Personnel							12
13	Nursing Administration	84,435	9,687			2,975		13
14	Central Services & Supply	16,863	16,826			5,168		14
15	Pharmacy	101,596	16,209			4,978		15
16	Medical Records & Library	170,576	127,007			39,005		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	549,223	235,718		125,329	72,393	181,911	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	173,030	156,954			48,202		50
53	Anesthesiology							53
54	Radiology-Diagnostic	371,728	115,931			35,604		54
60	Laboratory	458,894	46,233			14,199		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	128,614	12,967			3,982		65
66	Physical Therapy	199,809		11,664		46,306		66
69	Electrocardiology	31,297	12,967			3,982		69
70	Electroencephalography	8,536	12,928			3,970		70
71	Medical Supplies Charged to Patients	92,078						71
72	Impl. Dev. Charged to Patients	3,189						72
73	Drugs Charged to Patients	103,608						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	139,318	99,645			30,602		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,163,234		44,974		178,551		88
90	Clinic	18,384						90
91	Emergency	564,803	107,865			33,127		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	330,064	48,009			14,744		95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	5,211,029	1,077,877	56,638	125,329	552,426	181,911	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,196	10,381			3,188		190
192	Physicians' Private Offices	12,764	50,942	3,314		28,801		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,224,989	1,139,200	59,952	125,329	584,415	181,911	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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	437,170						11
12	Maintenance of Personnel							12
13	Nursing Administration	10,472	436,164					13
14	Central Services & Supply	1,377	2,587	108,448				14
15	Pharmacy	8,610		905	527,681			15
16	Medical Records & Library	17,978				1,018,395		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	68,553	128,748	2,317		46,214	3,547,820	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,306	32,501	25,296		52,672	1,179,343	50
53	Anesthesiology							53
54	Radiology-Diagnostic	20,558	38,609	6,046		271,008	2,306,137	54
60	Laboratory	27,206	51,095	50,292		171,195	2,604,991	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	15,718	36,899	1,439		19,530	719,676	65
66	Physical Therapy	24,442		270		40,479	1,100,568	66
69	Electrocardiology	2,947		155		18,544	191,689	69
70	Electroencephalography	982				3,023	62,658	70
71	Medical Supplies Charged to Patients			9,252		52,250	511,919	71
72	Impl. Dev. Charged to Patients			1,175		723	17,496	72
73	Drugs Charged to Patients				527,681	102,544	1,137,046	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					17,762	829,511	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	140,853		5,648		60,879	6,121,090	88
90	Clinic	2,563				91	92,584	90
91	Emergency	36,610	68,733	3,787		113,750	3,126,720	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	40,995	76,992	1,847		47,731	1,844,891	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)	437,170	436,164	108,429	527,681	1,018,395	25,394,139	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						19,419	190
192	Physicians' Private Offices			19			145,514	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	437,170	436,164	108,448	527,681	1,018,395	25,559,072	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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		3,547,820					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,179,343					50
53	Anesthesiology							53
54	Radiology-Diagnostic		2,306,137					54
60	Laboratory		2,604,991					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		719,676					65
66	Physical Therapy		1,100,568					66
69	Electrocardiology		191,689					69
70	Electroencephalography		62,658					70
71	Medical Supplies Charged to Patients		511,919					71
72	Impl. Dev. Charged to Patients		17,496					72
73	Drugs Charged to Patients		1,137,046					73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		829,511					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		6,121,090					88
90	Clinic		92,584					90
91	Emergency		3,126,720					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		1,844,891					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)		25,394,139					118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		19,419					190
192	Physicians' Private Offices		145,514					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		25,559,072					202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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		185,195		215,668	400,863	400,863	5
6	Maintenance & Repairs							6
7	Operation of Plant		3,206		3,733	6,939	17,867	7
7.01	RHC UTILITY EXPENSE						940	7.01
8	Laundry & Linen Service						1,966	8
9	Housekeeping		2,334		2,718	5,052	8,989	9
10	Dietary		7,474		11,497	18,971	2,113	10
11	Cafeteria		2,398			2,398	6,619	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,006		2,337	4,343	6,478	13
14	Central Services & Supply		3,485		4,059	7,544	1,294	14
15	Pharmacy		3,357		3,910	7,267	7,795	15
16	Medical Records & Library		26,308		30,637	56,945	13,087	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		48,827		56,862	105,689	42,137	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		32,511		37,861	70,372	13,275	50
53	Anesthesiology							53
54	Radiology-Diagnostic		24,014		27,965	51,979	28,519	54
60	Laboratory		9,577		11,153	20,730	35,207	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		2,686		3,128	5,814	9,867	65
66	Physical Therapy			38,493	36,372	74,865	15,330	66
69	Electrocardiology		2,686		3,128	5,814	2,401	69
70	Electroencephalography		2,678		3,119	5,797	655	70
71	Medical Supplies Charged to Patients						7,064	71
72	Impl. Dev. Charged to Patients						245	72
73	Drugs Charged to Patients						7,949	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		20,640		24,037	44,677	10,689	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			148,424	140,245	288,669	89,241	88
90	Clinic						1,410	90
91	Emergency		22,343		26,020	48,363	43,332	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		9,944		11,581	21,525	25,323	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)		411,669	186,917	656,030	1,254,616	399,792	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		2,150		2,504	4,654	92	190
192	Physicians' Private Offices		10,552	10,936	22,622	44,110	979	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		424,371	197,853	681,156	1,303,380	400,863	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	RHC UTILITY EXPENSE	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		7	7.01	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	24,806						7
7.01	RHC UTILITY EXPENSE		940					7.01
8	Laundry & Linen Service			1,966				8
9	Housekeeping	245			14,286			9
10	Dietary	786			271	22,141		10
11	Cafeteria	252			87		9,356	11
12	Maintenance of Personnel							12
13	Nursing Administration	211			73		224	13
14	Central Services & Supply	366			126		29	14
15	Pharmacy	353			122		184	15
16	Medical Records & Library	2,766			953		385	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,133		1,966	1,770	22,141	1,467	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,418			1,178		370	50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,524			870		440	54
60	Laboratory	1,007			347		582	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	282			97		336	65
66	Physical Therapy		183		1,132		523	66
69	Electrocardiology	282			97		63	69
70	Electroencephalography	282			97		21	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	2,170			748			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		705		4,366		3,017	88
90	Clinic						55	90
91	Emergency	2,349			810		783	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,045			360		877	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)	23,471	888	1,966	13,504	22,141	9,356	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	226			78			190
192	Physicians' Private Offices	1,109	52		704			192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,806	940	1,966	14,286	22,141	9,356	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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	11,329						13
14	Central Services & Supply	67	9,426					14
15	Pharmacy		79	15,800				15
16	Medical Records & Library				74,136			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	3,345	201		3,363	187,212		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	844	2,199		3,833	95,489		50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,003	525		19,751	105,611		54
60	Laboratory	1,327	4,372		12,457	76,029		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	958	125		1,421	18,900		65
66	Physical Therapy		23		2,946	95,002		66
69	Electrocardiology		13		1,349	10,019		69
70	Electroencephalography				220	7,072		70
71	Medical Supplies Charged to Patients		804		3,802	11,670		71
72	Impl. Dev. Charged to Patients		102		53	400		72
73	Drugs Charged to Patients			15,800	7,462	31,211		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				1,292	59,576		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		491		4,430	390,919		88
90	Clinic				7	1,472		90
91	Emergency	1,785	329		8,277	106,028		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	2,000	161		3,473	54,764		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)	11,329	9,424	15,800	74,136	1,251,374		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					5,050		190
192	Physicians' Private Offices		2			46,956		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	11,329	9,426	15,800	74,136	1,303,380		202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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	187,212						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	95,489						50
53	Anesthesiology							53
54	Radiology-Diagnostic	105,611						54
60	Laboratory	76,029						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,900						65
66	Physical Therapy	95,002						66
69	Electrocardiology	10,019						69
70	Electroencephalography	7,072						70
71	Medical Supplies Charged to Patients	11,670						71
72	Impl. Dev. Charged to Patients	400						72
73	Drugs Charged to Patients	31,211						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	59,576						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	390,919						88
90	Clinic	1,472						90
91	Emergency	106,028						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	54,764						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)	1,251,374						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,050						190
192	Physicians' Private Offices	46,956						192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,303,380						202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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 DEPARTMEN T GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
		1	1.01	2	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	53,087						1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT		20,082					1.01
2	Cap Rel Costs-Myble Equip			73,169				2
4	Employee Benefits Department				12,285,613			4
5	Administrative & General	23,167		23,167	2,025,596	-5,224,989	20,334,083	5
6	Maintenance & Repairs							6
7	Operation of Plant	401		401	276,702		906,316	7
7.01	RHC UTILITY EXPENSE						47,696	7.01
8	Laundry & Linen Service						99,708	8
9	Housekeeping	292		292	314,502		455,979	9
10	Dietary	935		1,235	50,685		107,199	10
11	Cafeteria	300			273,372		335,760	11
12	Maintenance of Personnel							12
13	Nursing Administration	251		251	223,851		328,595	13
14	Central Services & Supply	436		436	29,445		65,627	14
15	Pharmacy	420		420	184,038		395,383	15
16	Medical Records & Library	3,291		3,291	384,287		663,829	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	1,465,370		2,137,414	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067		4,067	369,919		673,382	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004		3,004	439,433		1,446,653	54
60	Laboratory	1,198		1,198	581,554		1,785,877	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336		336	335,981		500,527	65
66	Physical Therapy		3,907	3,907	522,469		777,598	66
69	Electrocardiology	336		336	62,996		121,797	69
70	Electroencephalography	335		335	20,999		33,219	70
71	Medical Supplies Charged to Patients						358,339	71
72	Impl. Dev. Charged to Patients						12,409	72
73	Drugs Charged to Patients						403,213	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582		2,582			542,184	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		15,065	15,065	3,010,758		4,526,951	88
90	Clinic				54,788		71,546	90
91	Emergency	2,795		2,795	782,569		2,198,045	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244		1,244	876,299		1,284,509	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	51,498	18,972	70,470	12,285,613	-5,224,989	20,279,755	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269		269			4,654	190
192	Physicians' Private Offices	1,320	1,110	2,430			49,674	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	424,371	197,853	681,156	3,757,688		5,224,989	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.993878	9.852256	9.309352	0.305861		0.256957	203
204	Cost to be allocated (Per Wkst. B, Part II)						400,863	204
205	Unit Cost Multiplier (Wkst. B, Part II)						0.019714	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

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 DEPARTMEN T GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	
		1	1.01	2	4	5A	5	
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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		20,082					7.01
8	Laundry & Linen Service			2,792				8
9	Housekeeping	292			49,309			9
10	Dietary	935			935	2,792		10
11	Cafeteria	300			300		9,344,756	11
12	Maintenance of Personnel							12
13	Nursing Administration	251			251		223,851	13
14	Central Services & Supply	436			436		29,445	14
15	Pharmacy	420			420		184,038	15
16	Medical Records & Library	3,291			3,291		384,287	16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,108		2,792	6,108	2,792	1,465,370	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,067			4,067		369,919	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,004			3,004		439,433	54
60	Laboratory	1,198			1,198		581,554	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	336			336		335,981	65
66	Physical Therapy		3,907		3,907		522,469	66
69	Electrocardiology	336			336		62,996	69
70	Electroencephalography	335			335		20,999	70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,582			2,582			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		15,065		15,065		3,010,758	88
90	Clinic						54,788	90
91	Emergency	2,795			2,795		782,569	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	1,244			1,244		876,299	95
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	27,930	18,972	2,792	46,610	2,792	9,344,756	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	269			269			190
192	Physicians' Private Offices	1,320	1,110		2,430			192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,139,200	59,952	125,329	584,415	181,911	437,170	202
203	Unit Cost Multiplier (Wkst. B, Part I)	38.592093	2.985360	44.888610	11.852096	65.154370	0.046782	203
204	Cost to be allocated (Per Wkst. B, Part II)	24,806	940	1,966	14,286	22,141	9,356	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.840340	0.046808	0.704155	0.289724	7.930158	0.001001	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT SQUARE FEET	RHC UTILITY EXPENSE SQUARE FEET	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE- KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	
		7	7.01	8	9	10	11	
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

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

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
7.01	RHC UTILITY EXPENSE							7.01
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	4,964,302						13
14	Central Services & Supply	29,445	1,145,482					14
15	Pharmacy		9,563	348,180				15
16	Medical Records & Library				67,365,864			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	1,465,370	24,473		3,057,065			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	369,919	267,192		3,484,287			50
53	Anesthesiology							53
54	Radiology-Diagnostic	439,433	63,857		17,925,696			54
60	Laboratory	581,554	531,211		11,324,672			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	419,976	15,197		1,291,927			65
66	Physical Therapy		2,850		2,677,743			66
69	Electrocardiology		1,636		1,226,700			69
70	Electroencephalography				200,000			70
71	Medical Supplies Charged to Patients		97,725		3,456,346			71
72	Impl. Dev. Charged to Patients		12,409		47,796			72
73	Drugs Charged to Patients			348,180	6,783,352			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES				1,174,977			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		59,661		4,027,216			88
90	Clinic				6,009			90
91	Emergency	782,306	40,000		7,524,648			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services	876,299	19,511		3,157,430			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)	4,964,302	1,145,285	348,180	67,365,864			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		197					192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	436,164	108,448	527,681	1,018,395			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.087860	0.094675	1.515541	0.015117			203
204	Cost to be allocated (Per Wkst. B, Part II)	11,329	9,426	15,800	74,136			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.002282	0.008229	0.045379	0.001100			205

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY GROSS REVENUE			
		13	14	15	16			
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
	COST CENTER DESCRIPTIONS	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,547,820		3,547,820			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,179,343		1,179,343			50
53	Anesthesiology						53
54	Radiology-Diagnostic	2,306,137		2,306,137			54
60	Laboratory	2,604,991		2,604,991			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	719,676		719,676			65
66	Physical Therapy	1,100,568		1,100,568			66
69	Electrocardiology	191,689		191,689			69
70	Electroencephalography	62,658		62,658			70
71	Medical Supplies Charged to Patients	511,919		511,919			71
72	Impl. Dev. Charged to Patients	17,496		17,496			72
73	Drugs Charged to Patients	1,137,046		1,137,046			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	829,511		829,511			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	6,121,090		6,121,090			88
90	Clinic	92,584		92,584			90
91	Emergency	3,126,720		3,126,720			91
92	Observation Beds (Non-Distinct Part)	621,062		621,062			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,844,891		1,844,891			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)	26,015,201		26,015,201			200
201	Less Observation Beds	621,062		621,062			201
202	Total (line 200 minus line 201)	25,394,139		25,394,139			202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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	1,814,328		1,814,328				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	450,770	3,033,517	3,484,287	0.338475			50
53	Anesthesiology							53
54	Radiology-Diagnostic	756,956	17,168,740	17,925,696	0.128650			54
60	Laboratory	1,061,702	10,262,970	11,324,672	0.230028			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	902,255	389,672	1,291,927	0.557056			65
66	Physical Therapy	417,477	2,260,266	2,677,743	0.411006			66
69	Electrocardiology	41,388	1,185,312	1,226,700	0.156264			69
70	Electroencephalography	5,000	195,000	200,000	0.313290			70
71	Medical Supplies Charged to Patients	1,815,016	1,641,330	3,456,346	0.148110			71
72	Impl. Dev. Charged to Patients	19,351	28,445	47,796	0.366056			72
73	Drugs Charged to Patients	2,616,721	4,166,631	6,783,352	0.167623			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1,174,977	1,174,977	0.705981			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		4,027,216	4,027,216				88
90	Clinic		6,009	6,009	15.407555			90
91	Emergency	181,615	7,343,033	7,524,648	0.415530			91
92	Observation Beds (Non-Distinct Part)	10,377	1,232,360	1,242,737	0.499753			92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		3,157,430	3,157,430	0.584301			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)	10,092,956	57,272,908	67,365,864				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	10,092,956	57,272,908	67,365,864				202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,547,820		3,547,820		3,547,820	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,179,343		1,179,343		1,179,343	50
53	Anesthesiology						53
54	Radiology-Diagnostic	2,306,137		2,306,137		2,306,137	54
60	Laboratory	2,604,991		2,604,991		2,604,991	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	719,676		719,676		719,676	65
66	Physical Therapy	1,100,568		1,100,568		1,100,568	66
69	Electrocardiology	191,689		191,689		191,689	69
70	Electroencephalography	62,658		62,658		62,658	70
71	Medical Supplies Charged to Patients	511,919		511,919		511,919	71
72	Impl. Dev. Charged to Patients	17,496		17,496		17,496	72
73	Drugs Charged to Patients	1,137,046		1,137,046		1,137,046	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	829,511		829,511		829,511	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	6,121,090		6,121,090		6,121,090	88
90	Clinic	92,584		92,584		92,584	90
91	Emergency	3,126,720		3,126,720		3,126,720	91
92	Observation Beds (Non-Distinct Part)	621,062		621,062			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services	1,844,891		1,844,891		1,844,891	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)	26,015,201		26,015,201		25,394,139	200
201	Less Observation Beds	621,062		621,062			201
202	Total (line 200 minus line 201)	25,394,139		25,394,139		25,394,139	202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

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	1,814,328		1,814,328				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	450,770	3,033,517	3,484,287	0.338475			50
53	Anesthesiology							53
54	Radiology-Diagnostic	756,956	17,168,740	17,925,696	0.128650			54
60	Laboratory	1,061,702	10,262,970	11,324,672	0.230028			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	902,255	389,672	1,291,927	0.557056			65
66	Physical Therapy	417,477	2,260,266	2,677,743	0.411006			66
69	Electrocardiology	41,388	1,185,312	1,226,700	0.156264			69
70	Electroencephalography	5,000	195,000	200,000	0.313290			70
71	Medical Supplies Charged to Patients	1,815,016	1,641,330	3,456,346	0.148110			71
72	Impl. Dev. Charged to Patients	19,351	28,445	47,796	0.366056			72
73	Drugs Charged to Patients	2,616,721	4,166,631	6,783,352	0.167623			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		1,174,977	1,174,977	0.705981			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		4,027,216	4,027,216				88
90	Clinic		6,009	6,009	15.407555			90
91	Emergency	181,615	7,343,033	7,524,648	0.415530			91
92	Observation Beds (Non-Distinct Part)	10,377	1,232,360	1,242,737	0.499753			92
	OTHER REIMBURSABLE COST CENTERS							
95	Ambulance Services		3,157,430	3,157,430	0.584301			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)	10,092,956	57,272,908	67,365,864				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	10,092,956	57,272,908	67,365,864				202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C
PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	1,179,343	95,489	1,083,854		50
53	Anesthesiology					53
54	Radiology-Diagnostic	2,306,137	105,611	2,200,526		54
60	Laboratory	2,604,991	76,029	2,528,962		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	719,676	18,900	700,776		65
66	Physical Therapy	1,100,568	95,002	1,005,566		66
69	Electrocardiology	191,689	10,019	181,670		69
70	Electroencephalography	62,658	7,072	55,586		70
71	Medical Supplies Charged to Patients	511,919	11,670	500,249		71
72	Impl. Dev. Charged to Patients	17,496	400	17,096		72
73	Drugs Charged to Patients	1,137,046	31,211	1,105,835		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	829,511	59,576	769,935		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	6,121,090	390,919	5,730,171		88
90	Clinic	92,584	1,472	91,112		90
91	Emergency	3,126,720	106,028	3,020,692		91
92	Observation Beds (Non-Distinct Part)	621,062	32,772	588,290		92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services	1,844,891	54,764	1,790,127		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	22,467,381	1,096,934	21,370,447		200
201	Less Observation Beds	621,062	32,772	588,290		201
202	Total	21,846,319	1,064,162	20,782,157		202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C
PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		1,179,343	3,484,287	0.338475	50
53	Anesthesiology					53
54	Radiology-Diagnostic		2,306,137	17,925,696	0.128650	54
60	Laboratory		2,604,991	11,324,672	0.230028	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		719,676	1,291,927	0.557056	65
66	Physical Therapy		1,100,568	2,677,743	0.411006	66
69	Electrocardiology		191,689	1,226,700	0.156264	69
70	Electroencephalography		62,658	200,000	0.313290	70
71	Medical Supplies Charged to Patients		511,919	3,456,346	0.148110	71
72	Impl. Dev. Charged to Patients		17,496	47,796	0.366056	72
73	Drugs Charged to Patients		1,137,046	6,783,352	0.167623	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		829,511	1,174,977	0.705981	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		6,121,090	4,027,216	1.519931	88
90	Clinic		92,584	6,009	15.407555	90
91	Emergency		3,126,720	7,524,648	0.415530	91
92	Observation Beds (Non-Distinct Part)		621,062	1,242,737	0.499753	92
	OTHER REIMBURSABLE COST CENTERS					
95	Ambulance Services		1,844,891	3,157,430	0.584301	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		22,467,381	65,551,536		200
201	Less Observation Beds		621,062	1,242,737		201
202	Total		21,846,319	64,308,799		202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.338475		1,330,392			450,304		50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.128650		7,409,764			953,266		54
60	Laboratory	0.230028		4,637,069			1,066,656		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.557056		115,369			64,267		65
66	Physical Therapy	0.411006		982,030			403,620		66
69	Electrocardiology	0.156264		631,409			98,666		69
70	Electroencephalography	0.313290		192,016			60,157		70
71	Medical Supplies Charged to Pat	0.148110		828,011			122,637		71
72	Impl. Dev. Charged to Patients	0.366056		27,123			9,929		72
73	Drugs Charged to Patients	0.167623		1,925,620			322,778		73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.705981		1,119,566			790,392		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	15.407555		5,769			88,886		90
91	Emergency	0.415530		2,631,342			1,093,402		91
92	Observation Beds (Non-Distinct	0.499753		524,468			262,104		92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.584301							95
200	Subtotal (see instructions)			22,359,948			5,787,064		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			22,359,948			5,787,064		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.338475							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.128650							54
60	Laboratory	0.230028							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.557056							65
66	Physical Therapy	0.411006							66
69	Electrocardiology	0.156264							69
70	Electroencephalography	0.313290							70
71	Medical Supplies Charged to Pat	0.148110							71
72	Impl. Dev. Charged to Patients	0.366056							72
73	Drugs Charged to Patients	0.167623							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.705981							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	15.407555							90
91	Emergency	0.415530							91
92	Observation Beds (Non-Distinct	0.499753							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.584301							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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check ☐ Title V
 Applicable ☐ Title XVIII, Part A
 Boxes: ☒ Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	187,212	31,339	155,873	2,283	68.28	156	10,652	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	187,212		155,873	2,283		156	10,652	200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1351

WORKSHEET D
PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other)
 Applicable ☐ Title XVIII, Part A ☐ IPF
 Boxes: ☒ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	95,489	3,484,287	0.027406			50
53	Anesthesiology						53
54	Radiology-Diagnostic	105,611	17,925,696	0.005892			54
60	Laboratory	76,029	11,324,672	0.006714			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,900	1,291,927	0.014629			65
66	Physical Therapy	95,002	2,677,743	0.035478			66
69	Electrocardiology	10,019	1,226,700	0.008167			69
70	Electroencephalography	7,072	200,000	0.035360			70
71	Medical Supplies Charged to Pat	11,670	3,456,346	0.003376			71
72	Impl. Dev. Charged to Patients	400	47,796	0.008369			72
73	Drugs Charged to Patients	31,211	6,783,352	0.004601			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	59,576	1,174,977	0.050704			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	390,919	4,027,216	0.097069			88
90	Clinic	1,472	6,009	0.244966			90
91	Emergency	106,028	7,524,648	0.014091			91
92	Observation Beds (Non-Distinct	32,772	1,242,737	0.026371			92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
200	Total (sum of lines 50-199)	1,042,170	62,394,106				200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check ☐ Title V ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ TEFRA
 Boxes: ☒ Title XIX ☒ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V

☐ Title XVIII, Part A

☒ Title XIX

☐ PPS

☐ TEFRA

☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,283		156		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	2,283		156		200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1351

**WORKSHEET D
PART IV**

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
53	Anesthesiology									53
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
95	Ambulance Services									95
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1351

**WORKSHEET D
PART IV**

Check ☐ Title V ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☒ Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	3,484,287							50
53	Anesthesiology								53
54	Radiology-Diagnostic	17,925,696							54
60	Laboratory	11,324,672							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,291,927							65
66	Physical Therapy	2,677,743							66
69	Electrocardiology	1,226,700							69
70	Electroencephalography	200,000							70
71	Medical Supplies Charged to Pat	3,456,346							71
72	Impl. Dev. Charged to Patients	47,796							72
73	Drugs Charged to Patients	6,783,352							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	1,174,977							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	4,027,216							88
90	Clinic	6,009							90
91	Emergency	7,524,648							91
92	Observation Beds (Non-Distinct	1,242,737							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services								95
200	Total (sum of lines 50-199)	62,394,106							200

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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/IID

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.338475							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.128650							54
60	Laboratory	0.230028							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.557056							65
66	Physical Therapy	0.411006							66
69	Electrocardiology	0.156264							69
70	Electroencephalography	0.313290							70
71	Medical Supplies Charged to Pat	0.148110							71
72	Impl. Dev. Charged to Patients	0.366056							72
73	Drugs Charged to Patients	0.167623							73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVI	0.705981							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	15.407555							90
91	Emergency	0.415530							91
92	Observation Beds (Non-Distinct	0.499753							92
	OTHER REIMBURSABLE COST CENTERS								
95	Ambulance Services	0.584301							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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PART I

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ 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)	2,742	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,283	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)	1,803	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	459	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)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,193	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)	459	10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.98	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20
21	Total general inpatient routine service cost (see instructions)	3,547,820	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)	593,891	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,953,929	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)	2,953,929	37

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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							1
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,293.88	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,543,599	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)					1,543,599	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,004,533	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,548,132	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)					593,891	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					593,891	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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					480	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,293.88	88
89	Observation bed cost (line 87 x line 88) (see instructions)					621,062	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	187,212	3,547,820	0.052768	621,062	32,772	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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PART I

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☐ 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)	2,742	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,283	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)	1,803	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	459	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)		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)	156	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	139.98	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.50	20
21	Total general inpatient routine service cost (see instructions)	3,547,820	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)	593,891	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,953,929	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)	2,953,929	37

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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

1

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,293.88	38
39	Program general inpatient routine service cost (line 9 x line 38)					201,845	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)					201,845	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

1

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					201,845	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		10,652	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)		10,652	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)			64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)			65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)			66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)			67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)			68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)			69

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1351

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					480	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,170,455		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.338475	197,698	66,916	50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.128650	288,817	37,156	54
60	Laboratory	0.230028	636,637	146,444	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.557056	555,377	309,376	65
66	Physical Therapy	0.411006	112,617	46,286	66
69	Electrocardiology	0.156264	25,812	4,033	69
70	Electroencephalography	0.313290	4,812	1,508	70
71	Medical Supplies Charged to Patients	0.148110	1,094,240	162,068	71
72	Impl. Dev. Charged to Patients	0.366056	5,942	2,175	72
73	Drugs Charged to Patients	0.167623	1,340,904	224,766	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.705981			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	15.407555			90
91	Emergency	0.415530	4,289	1,782	91
92	Observation Beds (Non-Distinct Part)	0.499753	4,048	2,023	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		4,271,193	1,004,533	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,271,193		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.338475			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.128650	12,380	1,593	54
60	Laboratory	0.230028	100,237	23,057	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.557056	190,155	105,927	65
66	Physical Therapy	0.411006	248,592	102,173	66
69	Electrocardiology	0.156264	1,476	231	69
70	Electroencephalography	0.313290			70
71	Medical Supplies Charged to Patients	0.148110	357,830	52,998	71
72	Impl. Dev. Charged to Patients	0.366056			72
73	Drugs Charged to Patients	0.167623	329,547	55,240	73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.705981			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	15.407555			90
91	Emergency	0.415530			91
92	Observation Beds (Non-Distinct Part)	0.499753	6,329	3,163	92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)		1,246,546	344,382	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,246,546		202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.338475			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.128650			54
60	Laboratory	0.230028			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.557056			65
66	Physical Therapy	0.411006			66
69	Electrocardiology	0.156264			69
70	Electroencephalography	0.313290			70
71	Medical Supplies Charged to Patients	0.148110			71
72	Impl. Dev. Charged to Patients	0.366056			72
73	Drugs Charged to Patients	0.167623			73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.705981			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	15.407555			90
91	Emergency	0.415530			91
92	Observation Beds (Non-Distinct Part)	0.499753			92
	OTHER REIMBURSABLE COST CENTERS				
95	Ambulance Services				95
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1351

WORKSHEET E
PART BCheck 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)	5,787,064			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,787,064			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 (see instructions)	5,844,935			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	46,192			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,526,223			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)	2,272,520			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)	2,272,520			30
31	Primary payer payments	695			31
32	Subtotal (line 30 minus line 31)	2,271,825			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)	233,186			34
35	Adjusted reimbursable bad debts (see instructions)	151,571			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	233,186			36
37	Subtotal (see instructions)	2,423,396			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)	2,423,396			40
40.01	Sequestration adjustment (see instructions)	48,468			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	2,465,487			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-90,559			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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			2,075,421		2,533,350
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					
3	List separately each retroactive lump sum adjustment	.01				3.01
	amount based on subsequent revision of the interim	.02				3.02
	rate for the cost reporting period. Also show date of	Program .03				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to .04				3.04
		Provider .05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51			02/25/2019	67,863
		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				-67,863
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)			2,075,421		2,465,487
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment	.01				5.01
	after desk review. Also show date of each payment.	.02				5.02
	If none, write 'NONE' or enter a zero. (1)	Program .03				5.03
		to .04				5.04
		Provider .05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		Provider .52				5.52
		to .53				5.53
		Program .54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due)	.01		179,678		6.01
	based on the cost report (1)	.02				-90,559
7	Total Medicare program liability (see instructions)			2,255,099		2,374,928
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			732,457		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment	.01				3.01
	amount based on subsequent revision of the interim	.02				3.02
	rate for the cost reporting period. Also show date of	Program .03				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to .04				3.04
		Provider .05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
		Provider .52				3.52
		to .53				3.53
		Program .54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			732,457		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment	.01				5.01
	after desk review. Also show date of each payment.	.02				5.02
	If none, write 'NONE' or enter a zero. (1)	Program .03				5.03
		to .04				5.04
		Provider .05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		Provider .52				5.52
		to .53				5.53
		Program .54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due)	.01		193,455		6.01
	based on the cost report (1)	.02				6.02
7	Total Medicare program liability (see instructions)			925,912		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

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

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z351

WORKSHEET E-2

Check ☐ Title V
 Applicable ☒ Title XVIII
 Boxes: ☐ Title XIX

☒ Swing Bed - SNF
☐ Swing Bed - NF

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	599,830		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	347,826		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	459		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)	947,656		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	947,656		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	947,656		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,848		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)	944,808		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)	944,808		19
19.01	Sequestration adjustment (see instructions)	18,896		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	732,457		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	193,455		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

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

1	Inpatient services	2,548,132	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,548,132	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,573,613	6
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
CUSTOMARY CHARGES			
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,573,613	19
20	Deductibles (exclude professional component)	286,299	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,287,314	22
23	Coinsurance	7,729	23
24	Subtotal (line 22 minus line 23)	2,279,585	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	33,133	25
26	Adjusted reimbursable bad debts (see instructions)	21,536	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	33,133	27
28	Subtotal (sum of lines 24 and 26)	2,301,121	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,301,121	30
30.01	Sequestration adjustment (see instructions)	46,022	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	2,075,421	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	179,678	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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1351

WORKSHEET E-3
PART VII

Check ☐ Title V ☒ Hospital ☐ NF ☐ PPS
 Applicable ☐ Title XIX ☐ SUB (Other) ☐ ICF/IID ☐ TEFRA
 Boxes: ☐ SNF ☒ Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	201,845		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	201,845		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	201,845		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	201,845		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	201,845		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	201,845		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	201,845		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	201,845		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	201,845		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	201,845		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	5,049,976				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	4,083,830				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable					6
7	Inventory	220,324				7
8	Prepaid expenses	670,998				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,025,128				11
FIXED ASSETS						
12	Land	135,111				12
13	Land improvements	351,668				13
14	Accumulated depreciation	-312,932				14
15	Buildings	13,438,329				15
16	Accumulated depreciation	-10,855,591				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	8,755,521				19
20	Accumulated depreciation	-7,063,293				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	1,574,330				27
28	Accumulated depreciation	-1,572,838				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	4,450,305				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	5,406,663				34
35	Total other assets (sum of lines 31-34)	5,406,663				35
36	Total assets (sum of lines 11, 30 and 35)	19,882,096				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	667,194				37
38	Salaries, wages and fees payable	1,010,566				38
39	Payroll taxes payable	52,000				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	617,541				44
45	Total current liabilities (sum of lines 37 thru 44)	2,347,301				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable					47
48	Unsecured loans					48
49	Other long term liabilities	7,549,066				49
50	Total long term liabilities (sum of lines 46 thru 49)	7,549,066				50
51	Total liabilities (sum of lines 45 and 50)	9,896,367				51
CAPITAL ACCOUNTS						
52	General fund balance	9,985,729				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	--------------------------------	--	--

BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets					
	(Omit Cents)	1	2	3	4	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	9,985,729				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	19,882,096				60

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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		10,768,959		1
2	Net income (loss) (from Worksheet G-3, line 29)		-783,230		2
3	Total (sum of line 1 and line 2)		9,985,729		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)		9,985,729		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)		9,985,729		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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	1,814,328		1,814,328	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	204,225		204,225	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)	2,018,553		2,018,553	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)	2,018,553		2,018,553	17
18	Ancillary services	8,395,965		8,395,965	18
19	Outpatient services		51,121,586	51,121,586	19
20	Rural Health Clinic (RHC)		4,027,716	4,027,716	20
20.01	RHC II				20.01
20.02	RHC III				20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance		3,157,430	3,157,430	23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	10,414,518	58,306,732	68,721,250	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		27,422,694	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)		27,422,694	43

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	68,721,250	1
2	Less contractual allowances and discounts on patients' accounts	44,289,516	2
3	Net patient revenues (line 1 minus line 2)	24,431,734	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	27,422,694	4
5	Net income from service to patients (line 3 minus line 4)	-2,990,960	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	425,120	6
7	Income from investments	20,963	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	142,496	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	9,150	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (TAX REVENUE)	203,900	24
24.0	Other (RENTAL INCOME)	54,324	24.0
1			1
24.0	Other (MISCELLANEOUS INCOME)	79,325	24.0
2			2
24.0	Other (GRANT INCOME)	99,721	24.0
3			3
24.0	Other (EHR INCENTIVE)	51,000	24.0
4			4
24.0	Other (340B PROGRAM REVENUE)	1,121,731	24.0
5			5
24.0	Other (SALE OF EQUIPMENT)		24.0
6			6
25	Total other income (sum of lines 6-24)	2,207,730	25
26	Total (line 5 plus line 25)	-783,230	26
27.0	Other expenses (LOSS ON INVESTMENTS)		27.0
1			1
29	Net income (or loss) for the period (line 26 minus line 28)	-783,230	29

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
1.01	NEW CAP RHC REL COSTS-BLDG & FIXT						1.01
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
7.01	RHC UTILITY EXPENSE						7.01
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
53	Anesthesiology						53
54	Radiology-Diagnostic						54
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76	PSYCHIATRIC/PSYCHOLOGICAL SERVICES						76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic						88
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
95	Ambulance Services						95
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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

COMPONENT CCN: 14-3458

WORKSHEET M-1

Check applicable box: ☒ RHC ☐ FQHC☐ FQHC

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATIO N (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	818,952		818,952		818,952		818,952	1
2	Physician Assistant								2
3	Nurse Practitioner	488,236		488,236		488,236		488,236	3
4	Visiting Nurse								4
5	Other Nurse	665,592		665,592		665,592		665,592	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	55,502		55,502		55,502		55,502	9
10	Subtotal (sum of lines 1 through 9)	2,028,282		2,028,282		2,028,282		2,028,282	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		91,356	91,356		91,356	-91,356		11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement		149,778	149,778		149,778	-5,850	143,928	13
14	Subtotal (sum of lines 11 through 13)		241,134	241,134		241,134	-97,206	143,928	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		29,947	29,947		29,947		29,947	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		1,093	1,093		1,093		1,093	18
19	Other Health Care Costs		193,887	193,887		193,887	-62,202	131,685	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		224,927	224,927		224,927	-62,202	162,725	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,028,282	466,061	2,494,343		2,494,343	-159,408	2,334,935	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.0	Telehealth								25.0
1									1
25.0	Chronic Care Management								25.0
2									2
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs	1,037,264		1,037,264	-54,788	982,476		982,476	29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)	1,037,264		1,037,264	-54,788	982,476		982,476	31
32	Total facility costs (sum of lines 22, 28 and 31)	3,065,546	466,061	3,531,607	-54,788	3,476,819	-159,408	3,317,411	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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3458

WORKSHEET M-2

Check applicable box: ☒ RHC ☐ FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.58	8,537	4,200	6,636		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	2.65	12,740	2,100	5,565		3
4	Subtotal (sum of lines 1 through 3)	4.23	21,277		12,201	21,277	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)	4.23	21,277			21,277	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	2,334,935	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)	2,334,935	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)	982,476	14
15	Parent provider overhead allocated to facility (see instructions)	2,803,679	15
16	Total overhead (sum of lines 14 and 15)	3,786,155	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	3,786,155	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	3,786,155	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	6,121,090	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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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)	6,121,090	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	88,750	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	6,032,340	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	21,277	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	21,277	6
7	Adjusted cost per visit (line 3 divided by line 6)	283.51	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)	283.51	283.51	283.51	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		5,016		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,422,086		11
12	Program covered visits for mental health services (from contractor records)		164		12
13	Program covered cost from mental health services (line 9 x line 12)		46,496		13
14	Limit adjustment for mental health services (see instructions)		46,496		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,468,582		16
16.01	Total program charges (see instructions)(from contractor's records)				16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		1,111,957		16.04
16.05	Total program cost (see instructions)		1,111,957		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		78,636		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		155,779		19
20	Net Medicare cost excluding vaccines (see instructions)		1,111,957		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		88,509		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,200,466		22
23	Allowable bad debts (see instructions)		13,557		23
23.01	Adjusted reimbursable bad debts (see instructions)		8,812		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,209,278		26
26.01	Sequestration adjustment (see instructions)		24,186		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		997,259		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		187,833		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: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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)	2,028,282	2,028,282	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001240	0.003369	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,515	6,833	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	18,810	5,696	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	21,325	12,529	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,334,935	2,334,935	6
7	Total overhead (from Wkst. M-2, line 16)	3,786,155	3,786,155	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.009133	0.005366	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	34,579	20,317	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	55,904	32,846	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	131	356	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	426.75	92.26	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	170	173	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	72,548	15,961	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)		88,750	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)		88,509	16

CLAY COUNTY HOSPITAL Provider CCN: 14-1351	In Lieu of Form CMS-2552-10	Period : From: 03/01/2018 To: 02/28/2019	Run Date: 07/29/2019 Run Time: 13:46 Version: 2018.12 (03/07/2019)
---	---------------------------------------	--	--

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

COMPONENT CCN: 14-3458

WORKSHEET M-5

Check applicable box: ☒ RHC ☐ FQHC

				Part B		
				mm/dd/yyyy	Amount	
DESCRIPTION				1	2	
1	Total interim payments paid to provider				879,656	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	02/25/2019	117,603	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			3.50
			.51	10/19/2017		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		117,603	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				997,259	
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		187,833	6.01
			.02			6.02
7	Total Medicare program liability (see instructions)				1,185,092	
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.