

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: 08-22-2013 TIME: 10:32
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY DR JOHN WARNER HOSPITAL (14-1303) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 05/01/2012 AND ENDING 04/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

 TITLE

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		35,052	30,591		46,626	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		-4,402				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			87,240			10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		30,650	117,831		46,626	200

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

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF
 UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS
 OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER
 OF UNWEIGHTED PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL.
 ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)).
 (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 XIX 2 N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			Y 106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N 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.			Y 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.		PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY	Y Y Y N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		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.	2		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 123,635 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

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

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	1 Y	2	140
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IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

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

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

	TITLE XVIII		TITLE V	TITLE XIX
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	N	N
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
08/22/2013 10:32

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

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

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

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

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

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

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

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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
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)	1 N	2	1	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	1 N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	N		3	
FINANCIAL DATA AND REPORTS					
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.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5	
APPROVED EDUCATIONAL ACTIVITIES					
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		1 N	2 6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y/N	Y/N 2	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			Y 12 N 13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N 14	
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			Y 15	
PS&R REPORT DATA					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 Y	2 06/12/2013	3 Y	4 06/12/2013
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	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.	Y		Y	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

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
 PART II

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

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

CAPITAL RELATED COST

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

INTEREST EXPENSE

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

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. N 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 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. N 35

HOME OFFICE COSTS

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

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|-------------------------------------|-----------------------------------|------------------|----|
| 41 FIRST NAME: AMBER | LAST NAME: HALSTEAD | TITLE: IN-CHARGE | 41 |
| 42 EMPLOYER: KERBER, ECK & BRAECKEL | | | 42 |
| 43 PHONE NUMBER: 618-529-1040 | E-MAIL ADDRESS: AMBERH@KEBCPA.COM | | 43 |

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200				1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A ADMINISTRATIVE					4
4.01	PHYSICIAN-PART A - TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN AN APPROVED PGM)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)					10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A - ADMINISTRATIVE					15
16	HOME OFFICE & CONTRACT PHYSICIANS-PART A - TEACHING					16
WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)					17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A - ADMINISTRATIVE					22
22.01	PHYSICIAN PART A - TEACHING					22.01
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS					26
27	ADMINISTRATIVE & GENERAL					27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT					30
31	LAUNDRY & LINEN SERVICE					31
32	HOUSEKEEPING					32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY					34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA					36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION					38
39	CENTRAL SERVICES AND SUPPLY					39
40	PHARMACY					40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY					41
42	SOCIAL SERVICE					42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

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

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

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

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
08/22/2013 10:32

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	03/01/2000	2

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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

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

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

RHC I
 COMPONENT NO: 14-3404

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 422 W WHITE STREET 1
 2 CITY: CLINTON STATE: IL ZIP CODE: 61727 COUNTY: DEWITT 2
 3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

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

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

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0730	1700	0730	1700	0730	1800	0730	1800	0730	1700	0900	1200	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.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2
 N 12

13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 13
 ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.

14 PROVIDER NAME: CCN NUMBER: 14

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

	Y/N	V	XVIII	XIX	TOTAL	
	N					15

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.590493	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,538,839	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?					4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID					5
6	MEDICAID CHARGES				4,726,498	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				2,790,964	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				1,252,125	8
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(SEE INSTRUCTIONS FOR EACH LINE)						
9	NET REVENUE FROM STAND-ALONE SCHIP					9
10	STAND-ALONE SCHIP CHARGES					10
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					12
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)						
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,252,125	19
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL		
		1	2	3		
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	274,258	35,613	309,871		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	161,947	21,029	182,976		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	22,310	5,535	27,845		22
23	COST OF CHARITY CARE	139,637	15,494	155,131		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, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)			1,451,296		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			261,640		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,189,656		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			702,484		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			857,615		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,109,740		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		318,957	318,957	77,320	1
2	00200		607,207	607,207	8,816	2
3	00300					3
4	00400		2,076,865	2,076,865		4
5	00500	988,344	927,407	1,915,751	250,982	5
6	00600					6
7	00700	159,354	342,246	501,600	1,142	7
8	00800		7,696	85,012	92,708	8
9	00900	109,106	34,534	143,640		9
10	01000	186,852	167,695	354,547	-17,691	10
11	01100				22,691	11
12	01200					12
13	01300	166,682	9,379	176,061	6,984	13
14	01400	14,092	93,331	107,423	-93,178	14
15	01500	120,989	619,694	740,683	-289,143	15
16	01600	131,860	95,005	226,865	8,033	16
17	01700	41,561	2,369	43,930		17
19	01900					19
20	02000				174,760	20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	899,363	288,959	1,188,322	-40,258	30
ANCILLARY SERVICE COST CENTERS						
50	05000	327,817	144,448	472,265	30	50
53	05300		182,127	182,127	-174,760	53
54	05400	219,117	642,207	861,324		54
60	06000	344,088	605,095	949,183	3,024	60
62	06200				2,501	62
62.30	06250					62.30
64	06400				83,449	64
65	06500	170,553	58,781	229,334	-30,013	65
66	06600	42,190	405,595	447,785	-21,718	66
67	06700					67
68	06800					68
69	06900	55,544	25,344	80,888		69
71	07100				123,191	71
72	07200		86,591	86,591		72
73	07300				289,143	73
76	03950	44,874	1,081	45,955		76
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	1,455,835	351,092	1,806,927	-313,949	88
90	09000				3,530	90
90.01	09001	210	28	238		90.01
91	09100	635,682	1,376,742	2,012,424	-43,774	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
95	09500	339,882	26,144	366,026	4,000	95
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
SPECIAL PURPOSE COST CENTERS						
113	11300		56,830	56,830	-56,830	113
118		6,461,691	9,630,765	16,092,456	-21,718	118
NONREIMBURSABLE COST CENTERS						
192	19200	56,582	4,698	61,280		192
192.01	19201					192.01
192.02	19202					192.02
192.03	19203				21,718	192.03
192.04	19204					192.04
200		6,518,273	9,635,463	16,153,736		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7	
GENERAL SERVICE COST CENTERS					
1	00100	396,277	-2,661	393,616	1
2	00200	616,023	-3,312	612,711	2
3	00300				3
4	00400	2,076,865		2,076,865	4
5	00500	2,166,733	-17,374	2,149,359	5
6	00600				6
7	00700	502,742		502,742	7
8	00800	92,708		92,708	8
9	00900	143,640		143,640	9
10	01000	336,856	-259,392	77,464	10
11	01100	22,691	-14,607	8,084	11
12	01200				12
13	01300	183,045	-3,865	179,180	13
14	01400	14,245		14,245	14
15	01500	451,540		451,540	15
16	01600	234,898	-4,685	230,213	16
17	01700	43,930		43,930	17
19	01900	174,760		174,760	19
20	02000				20
21	02100				21
22	02200				22
23	02300				23
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,148,064	-40,844	1,107,220	30
ADULTS & PEDIATRICS					
ANCILLARY SERVICE COST CENTERS					
50	05000	472,295	-96,662	375,633	50
53	05300	7,367		7,367	53
54	05400	861,324		861,324	54
60	06000	952,207	-3,129	949,078	60
62	06200	2,501		2,501	62
62.30	06250				62.30
64	06400	83,449		83,449	64
65	06500	199,321	-844	198,477	65
66	06600	426,067	-10,194	415,873	66
67	06700				67
68	06800				68
69	06900	80,888	-29,233	51,655	69
71	07100	123,191	-1,112	122,079	71
72	07200	86,591		86,591	72
73	07300	289,143	-31,750	257,393	73
76	03950	45,955		45,955	76
76.97	07697				76.97
76.98	07698				76.98
76.99	07699				76.99
OUTPATIENT SERVICE COST CENTERS					
88	08800	1,492,978	-56,882	1,436,096	88
90	09000	3,530		3,530	90
90.01	09001	238		238	90.01
91	09100	1,968,650	-826,136	1,142,514	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
95	09500	370,026		370,026	95
99.10	09910				99.10
99.20	09920				99.20
99.30	09930				99.30
99.40	09940				99.40
SPECIAL PURPOSE COST CENTERS					
113	11300				113
118		16,070,738	-1,402,682	14,668,056	118
NONREIMBURSABLE COST CENTERS					
192	19200	61,280		61,280	192
192.01	19201				192.01
192.02	19202				192.02
192.03	19203	21,718		21,718	192.03
192.04	19204		1,789	1,789	192.04
200		16,153,736	-1,400,893	14,752,843	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
	1	2	3	4	5	
1 TO RECLASS CAFETERIA COSTS FROM DIET	A	CAFETERIA	11	11,959	10,732	1
500 TOTAL RECLASSIFICATIONS				11,959	10,732	500
CODE LETTER - A						
1 TO RECLASS DRUGS SOLD TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73		289,143	1
500 TOTAL RECLASSIFICATIONS					289,143	500
CODE LETTER - B						
1 TO RECLASS INTEREST EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		56,830	1
500 TOTAL RECLASSIFICATIONS					56,830	500
CODE LETTER - C						
1 TO RECLASS SUPPLIES CHARGED TO PTS	D	MEDICAL SUPPLIES CHRGD TO PA	71		93,178	1
500 TOTAL RECLASSIFICATIONS					93,178	500
CODE LETTER - D						
1 TO RECLASS ER PHYSICIAN CONTRACTED	E	ADMINISTRATIVE & GENERAL	5		20,487	1
500 TOTAL RECLASSIFICATIONS					20,487	500
CODE LETTER - E						
1 TO RECLASS PROPERTY INS EXP	F	OTHER CAPITAL RELATED COSTS	3		29,306	1
500 TOTAL RECLASSIFICATIONS					29,306	500
CODE LETTER - F						
1 TO RECLASS RHC ADMIN EXPENSES	G	ADMINISTRATIVE & GENERAL	5		120,746	1
500 TOTAL RECLASSIFICATIONS					120,746	500
CODE LETTER - G						
1 TO RECLASS OXYGEN SUPPLIES	H	MEDICAL SUPPLIES CHRGD TO PA	71		30,013	1
500 TOTAL RECLASSIFICATIONS					30,013	500
CODE LETTER - H						
1 TO RECLASS NURSING COST	I	INTRAVENOUS THERAPY	64	39,227		1
500 TOTAL RECLASSIFICATIONS				39,227		500
CODE LETTER - I						
1 TO RECLASS NURSING COST	J	INTRAVENOUS THERAPY	64	209		1
500 TOTAL RECLASSIFICATIONS				209		500
CODE LETTER - J						
1 TO RECLASS NURSING COST	K	INTRAVENOUS THERAPY	64	44,013		1
500 TOTAL RECLASSIFICATIONS				44,013		500
CODE LETTER - K						
1 TO RECLASS NURSING COST	L	WHOLE BLOOD & PACKED RED BLOO	62	2,501		1
500 TOTAL RECLASSIFICATIONS				2,501		500
CODE LETTER - L						
1 TO RECLASS NURSING COST	M	CLINIC	90	3,530		1
500 TOTAL RECLASSIFICATIONS				3,530		500
CODE LETTER - M						
1 TO RECLASS GRANT EXPENSES	N	OPERATION OF PLANT	7		1,142	1
2		DIETARY	10		5,000	2
3		NURSING ADMINISTRATION	13		6,779	3
4		MEDICAL RECORDS & LIBRARY	16		8,033	4
5		ADULTS & PEDIATRICS	30		5,000	5
6		EMERGENCY	91		20,726	6
7		AMBULANCE SERVICES	95		4,000	7
500 TOTAL RECLASSIFICATIONS					50,680	500
CODE LETTER - N						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----		SALARY	OTHER
		COST CENTER	LINE #		
	1	2	3	4	5
1 TO RECLASS RESTRICTED DONATIONS	O	NURSING ADMINISTRATION	13		205 1
2		OPERATING ROOM	50		239 2
500 TOTAL RECLASSIFICATIONS					444 500
CODE LETTER - O					
1 TO RECLASS RHC PHYSICIAN ADMIN TIME	P	ADMINISTRATIVE & GENERAL	5	190,179	1
500 TOTAL RECLASSIFICATIONS				190,179	500
CODE LETTER - P					
1 TO RECLASS ATHLETIC TRAINER BENEFIT	Q	COMMUNITY BENEFIT	192.03		21,718 1
500 TOTAL RECLASSIFICATIONS					21,718 500
CODE LETTER - Q					
1 TO RECLASS CRNA EXPENSE AFTER 12/31	R	NONPHYSICIAN ANESTHETISTS	19		174,760 1
500 TOTAL RECLASSIFICATIONS					174,760 500
CODE LETTER - R					
1 TO RECLASS LAB TESTS DONE IN RHC	S	LABORATORY	60		3,024 1
500 TOTAL RECLASSIFICATIONS					3,024 500
CODE LETTER - S					
GRAND TOTAL (INCREASES)				291,618	901,061

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 TO RECLASS CAFETERIA COSTS FROM DIET	A	DIETARY	10	11,959	10,732	1
500 TOTAL RECLASSIFICATIONS				11,959	10,732	500
CODE LETTER - A						
1 TO RECLASS DRUGS SOLD TO PATIENTS	B	PHARMACY	15		289,143	1
500 TOTAL RECLASSIFICATIONS					289,143	500
CODE LETTER - B						
1 TO RECLASS INTEREST EXPENSE	C	INTEREST EXPENSE	113		56,830	11 1
500 TOTAL RECLASSIFICATIONS					56,830	500
CODE LETTER - C						
1 TO RECLASS SUPPLIES CHARGED TO PTS	D	CENTRAL SERVICES & SUPPLY	14		93,178	1
500 TOTAL RECLASSIFICATIONS					93,178	500
CODE LETTER - D						
1 TO RECLASS ER PHYSICIAN CONTRACTED	E	EMERGENCY	91		20,487	1
500 TOTAL RECLASSIFICATIONS					20,487	500
CODE LETTER - E						
1 TO RECLASS PROPERTY INS EXP	F	ADMINISTRATIVE & GENERAL	5		29,306	12 1
500 TOTAL RECLASSIFICATIONS					29,306	500
CODE LETTER - F						
1 TO RECLASS RHC ADMIN EXPENSES	G	RURAL HEALTH CLINIC (RHC)	88		120,746	1
500 TOTAL RECLASSIFICATIONS					120,746	500
CODE LETTER - G						
1 TO RECLASS OXYGEN SUPPLIES	H	RESPIRATORY THERAPY	65		30,013	1
500 TOTAL RECLASSIFICATIONS					30,013	500
CODE LETTER - H						
1 TO RECLASS NURSING COST	I	ADULTS & PEDIATRICS	30	39,227		1
500 TOTAL RECLASSIFICATIONS				39,227		500
CODE LETTER - I						
1 TO RECLASS NURSING COST	J	OPERATING ROOM	50	209		1
500 TOTAL RECLASSIFICATIONS				209		500
CODE LETTER - J						
1 TO RECLASS NURSING COST	K	EMERGENCY	91	44,013		1
500 TOTAL RECLASSIFICATIONS				44,013		500
CODE LETTER - K						
1 TO RECLASS NURSING COST	L	ADULTS & PEDIATRICS	30	2,501		1
500 TOTAL RECLASSIFICATIONS				2,501		500
CODE LETTER - L						
1 TO RECLASS NURSING COST	M	ADULTS & PEDIATRICS	30	3,530		1
500 TOTAL RECLASSIFICATIONS				3,530		500
CODE LETTER - M						
1 TO RECLASS GRANT EXPENSES	N	ADMINISTRATIVE & GENERAL	5		50,680	1
2						2
3						3
4						4
5						5
6						6
7						7
500 TOTAL RECLASSIFICATIONS					50,680	500
CODE LETTER - N						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 TO RECLASS RESTRICTED DONATIONS	O	ADMINISTRATIVE & GENERAL	5		444	1
2						2
500 TOTAL RECLASSIFICATIONS					444	500
CODE LETTER - O						
1 TO RECLASS RHC PHYSICIAN ADMIN TIME	P	RURAL HEALTH CLINIC (RHC)	88	190,179		1
500 TOTAL RECLASSIFICATIONS				190,179		500
CODE LETTER - P						
1 TO RECLASS ATHLETIC TRAINER BENEFIT	Q	PHYSICAL THERAPY	66		21,718	1
500 TOTAL RECLASSIFICATIONS					21,718	500
CODE LETTER - Q						
1 TO RECLASS CRNA EXPENSE AFTER 12/31	R	ANESTHESIOLOGY	53		174,760	1
500 TOTAL RECLASSIFICATIONS					174,760	500
CODE LETTER - R						
1 TO RECLASS LAB TESTS DONE IN RHC	S	RURAL HEALTH CLINIC (RHC)	88		3,024	1
500 TOTAL RECLASSIFICATIONS					3,024	500
CODE LETTER - S						
GRAND TOTAL (DECREASES)				291,618	901,061	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	310,078	33,510		33,510		343,588	1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES	9,982,710	589,225		589,225	58,732	10,513,203	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT	129,865	10,969		10,969	7,472	133,362	5
6 MOVABLE EQUIPMENT	5,203,628	137,178		137,178	759,745	4,581,061	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	15,626,281	770,882		770,882	825,949	15,571,214	8
9 RECONCILING ITEMS	3,626	418,718		418,718	422,344		9
10 TOTAL (LINE 7 MINUS LINE 9)	15,622,655	352,164		352,164	403,605	15,571,214	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	318,957						318,957 1
2 CAP REL COSTS-MVBLE EQUIP	607,207						607,207 2
3 TOTAL (SUM OF LINES 1-2)	926,164						926,164 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION OF RATIOS

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	OF RATIOS		INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
			FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4				
1 CAP REL COSTS-BLDG & FIXT	10,646,566		10,646,566	0.699161	20,490			20,490 1
2 CAP REL COSTS-MVBLE EQUIP	4,581,061		4,581,061	0.300839	8,816			8,816 2
3 TOTAL (SUM OF LINES 1-2)	15,227,627		15,227,627	1.000000	29,306			29,306 3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	318,957			54,169	20,490		393,616 1
2 CAP REL COSTS-MVBLE EQUIP	603,895				8,816		612,711 2
3 TOTAL	922,852			54,169	29,306		1,006,327 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
			COST CENTER	LINE NO.	WKST A-7 REF
	1	2	3	4	5
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	B	-2,661	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)	B	-8,119	ADMINISTRATIVE & GENERAL	5	11 3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)					7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)					8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,045,640			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1	52,801			12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-14,607	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-1,112	MEDICAL SUPPLIES CHRGED TO PATI	71	16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-987	DRUGS CHARGED TO PATIENTS	73	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4,685	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114	25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29 PHYSICIANS' ASSISTANT					29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32 CAH HIT ADJ FOR DEPRECIATION AND					32
33 OTHER INCOME	B	-2,806	ADMINISTRATIVE & GENERAL	5	33
34 OUTSIDE DIETARY SERVICES	B	-259,392	DIETARY	10	34
35 DEPRECIATION OF NON-ALLOW TVS	A	-3,312	CAP REL COSTS-MVBLE EQUIP	2	9 35
36 FITNESS MGMT	B	-9,621	PHYSICAL THERAPY	66	36
37 OUTSIDE LAB SERVICES	B	-3,129	LABORATORY	60	37
38 OTHER REVENUE - RHC	B	-4,117	RURAL HEALTH CLINIC (RHC)	88	38
39 CONTRIBUTIONS	A	-1,959	ADMINISTRATIVE & GENERAL	5	39
40 LOBBYING EXPENSE	A	-8,685	ADMINISTRATIVE & GENERAL	5	40
41 ADVERTISING EXPENSE	A	-33,252	ADMINISTRATIVE & GENERAL	5	41
42 MARKETING OTHER EXPENSE	A	-15,354	ADMINISTRATIVE & GENERAL	5	42
43 RENTAL HOUSE EXPENSE	A	1,789	RENTAL PROPERTIES	192.04	43
44 CLINICAL TRAINING CLASSES	A	-3,865	NURSING ADMINISTRATION	13	44
45 NON-ALLOW PURCH SVC - CABLE TV	A	-573	PHYSICAL THERAPY	66	45
46 PHARMACY 340B REVENUE IN EXCESS OF	B	-30,763	DRUGS CHARGED TO PATIENTS	73	46
47					47
48 RESTING METABOLIC	B	-844	RESPIRATORY THERAPY	65	48
49					49
50 TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-1,400,893			50

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

WORKSHEET A-8-1

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

LINE NO. 1	COST CENTER 2	EXPENSE ITEMS 3	AMOUNT OF ALLOWABLE COST 4	AMOUNT (INCL IN WKST A, COL. 5) 5	NET ADJ- USTMENTS (COL. 4-5) 6	WKST A-7 REF 7
1	5	ADMINISTRATIVE & GENERAL				
2		ADMINISTRATION & GENERAL	52,801		52,801	1
3						2
4						3
5		TOTALS (SUM OF LINES 1-4)	52,801		52,801	4
		TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.				5

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

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

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

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:

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

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 60	LABORATORY	1,717		1,717				1
2 69	ELECTROCARDIOLOGY	29,233	29,233					2
3 91	EMERGENCY	1,251,542	826,136	425,406				3
4 88	RURAL HEALTH CLINIC (RHC)	841,161	52,765	788,396				4
5 50	OPERATING ROOM	96,662	96,662					5
6 30	ADULTS & PEDIATRICS	40,844	40,844					6
7 91	EMERGENCY	33,780		33,780				7
200	TOTAL	2,294,939	1,045,640	1,249,299				200

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF COLUMN 12	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF COLUMN 14	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT	
LINE NO.	11	12	13	14	15	16	17	18	
1	60 LABORATORY								1
2	69 ELECTROCARDIOLOGY	AGGREGATE						29,233	2
3	91 EMERGENCY	CORE						826,136	3
4	88 RURAL HEALTH CLINIC (RHC)	AGGREGATE						52,765	4
5	50 OPERATING ROOM	AGGREGATE						96,662	5
6	30 ADULTS & PEDIATRICS	HOSPITALIST						40,844	6
7	91 EMERGENCY	EPSS							7
200	TOTAL							1,045,640	200

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3
 PARTS I & II

[XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					1	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					15	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE					1	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					0.49	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED			1.00			9
10	AHSEA		69.82	52.36			10
11	STANDARD TRAVEL ALLOWANCE	34.91	34.91	26.18			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS						15
16	ASSISTANTS					52	16
17	SUBTOTAL ALLOWANCE AMOUNT					52	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					52	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					52.00	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					780	22
23	TOTAL SALARY EQUIVALENCY					780	23

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3
PARTS III & IV

[XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE		
24 THERAPISTS		24
25 ASSISTANTS	26	25
26 SUBTOTAL	26	26
27 STANDARD TRAVEL EXPENSE	5	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	31	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29 THERAPISTS		29
30 ASSISTANTS		30
31 SUBTOTAL		31
32 OPTIONAL TRAVEL EXPENSE		32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	31	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE

36 THERAPISTS		36
37 ASSISTANTS		37
38 SUBTOTAL		38
39 STANDARD TRAVEL EXPENSE		39

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

40 THERAPISTS		40
41 ASSISTANTS		41
42 SUBTOTAL		42
43 OPTIONAL TRAVEL EXPENSE		43

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3
 PARTS V,VI & VII

[XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					780	57
58					31	58
59						59
60						60
61						61
62						62
63					811	63
64					25	64
65						65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-3
 PARTS I & II

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					12	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					180	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					273	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE					245	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					0.49	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		3,822.50	2,135.25			9
10	AHSEA		73.67	55.25			10
11	STANDARD TRAVEL ALLOWANCE	36.84	36.84	27.63			11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					281,604	15
16	ASSISTANTS					117,973	16
17	SUBTOTAL ALLOWANCE AMOUNT					399,577	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					399,577	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					399,577	23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-3
PARTS III & IV

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE		
24 THERAPISTS	10,057	24
25 ASSISTANTS	6,769	25
26 SUBTOTAL	16,826	26
27 STANDARD TRAVEL EXPENSE	2,512	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	19,338	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29 THERAPISTS		29
30 ASSISTANTS		30
31 SUBTOTAL		31
32 OPTIONAL TRAVEL EXPENSE		32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	19,338	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE

36 THERAPISTS		36
37 ASSISTANTS		37
38 SUBTOTAL		38
39 STANDARD TRAVEL EXPENSE		39

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

40 THERAPISTS		40
41 ASSISTANTS		41
42 SUBTOTAL		42
43 OPTIONAL TRAVEL EXPENSE		43

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-3
PARTS V,VI & VII

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					399,577	57
58					19,338	58
59						59
60						60
61						61
62						62
63					418,915	63
64					264,816	64
65						65

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
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WORKSHEET A-8-3
PARTS I & II

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					2	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					30	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					7	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					4.85	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					0.49	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		28.75				9
10	AHSEA		67.09				10
11	STANDARD TRAVEL ALLOWANCE	33.55	33.55				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					1,929	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					1,929	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					1,929	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					67.10	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					2,013	22
23	TOTAL SALARY EQUIVALENCY					2,013	23

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WORKSHEET A-8-3
PARTS III & IV

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE		
24 THERAPISTS	235	24
25 ASSISTANTS		25
26 SUBTOTAL	235	26
27 STANDARD TRAVEL EXPENSE	34	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	269	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
29 THERAPISTS		29
30 ASSISTANTS		30
31 SUBTOTAL		31
32 OPTIONAL TRAVEL EXPENSE		32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	269	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE		
36 THERAPISTS		36
37 ASSISTANTS		37
38 SUBTOTAL		38
39 STANDARD TRAVEL EXPENSE		39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		
40 THERAPISTS		40
41 ASSISTANTS		41
42 SUBTOTAL		42
43 OPTIONAL TRAVEL EXPENSE		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES		
44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

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WORKSHEET A-8-3
 PARTS V,VI & VII

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					2,013	57
58					269	58
59						59
60						60
61						61
62						62
63					2,282	63
64					1,979	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	393,616	393,616				1
2 CAP REL COSTS-MVBLE EQUIP	612,711		612,711			2
4 EMPLOYEE BENEFITS	2,076,865	2,347	3,653	2,082,865		4
5 ADMINISTRATIVE & GENERAL	2,149,359	41,930	65,269	376,588	2,633,146	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	502,742	71,804	111,778	50,920	737,244	7
8 LAUNDRY & LINEN SERVICE	92,708	4,631	7,209	2,459	107,007	8
9 HOUSEKEEPING	143,640	2,296	3,574	34,864	184,374	9
10 DIETARY	77,464	12,115	18,858	55,886	164,323	10
11 CAFETERIA	8,084			3,821	11,905	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	179,180	2,217	3,452	53,262	238,111	13
14 CENTRAL SERVICES & SUPPLY	14,245	7,899	12,295	4,503	38,942	14
15 PHARMACY	451,540	6,737	10,486	38,661	507,424	15
16 MEDICAL RECORDS & LIBRARY	230,213	8,724	13,580	42,135	294,652	16
17 SOCIAL SERVICE	43,930			13,280	57,210	17
19 NONPHYSICIAN ANESTHETISTS	174,760				174,760	19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,107,220	47,853	74,488	272,922	1,502,483	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	375,633	26,947	41,946	104,685	549,211	50
53 ANESTHESIOLOGY	7,367	1,005	1,564		9,936	53
54 RADIOLOGY-DIAGNOSTIC	861,324	25,886	40,294	70,017	997,521	54
60 LABORATORY	949,078	7,360	11,456	109,951	1,077,845	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,501			799	3,300	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	83,449			26,665	110,114	64
65 RESPIRATORY THERAPY	198,477	1,381	2,150	54,499	256,507	65
66 PHYSICAL THERAPY	415,873	14,108	21,960	13,481	465,422	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	51,655	1,381	2,150	17,749	72,935	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	122,079				122,079	71
72 IMPL. DEV. CHARGED TO PATIENT	86,591				86,591	72
73 DRUGS CHARGED TO PATIENTS	257,393				257,393	73
76 CARDIAC REHAB	45,955	1,606	2,499	14,339	64,399	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,436,096	48,195	75,021	404,434	1,963,746	88
90 CLINIC	3,530			1,128	4,658	90
90.01 PROVIDER BASED CLINIC	238	174	271	67	750	90.01
91 EMERGENCY	1,142,514	15,775	24,556	189,063	1,371,908	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	370,026	8,303	12,924	108,607	499,860	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						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	14,668,056	360,674	561,433	2,064,785	14,565,756	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	61,280	25,476	39,656	18,080	144,492	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	21,718				21,718	192.03
192.04 RENTAL PROPERTIES	1,789	7,466	11,622		20,877	192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	14,752,843	393,616	612,711	2,082,865	14,752,843	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	2,633,146					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	160,175	897,419				7
8 LAUNDRY & LINEN SERVICE	23,249	15,390	145,646			8
9 HOUSEKEEPING	40,057	7,630		232,061		9
10 DIETARY	35,701	40,257		10,389	250,670	10
11 CAFETERIA	2,587					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	51,732	7,369		1,902		13
14 CENTRAL SERVICES & SUPPLY	8,461	26,247		6,774		14
15 PHARMACY	110,244	22,386		5,777		15
16 MEDICAL RECORDS & LIBRARY	64,017	28,989		7,481		16
17 SOCIAL SERVICE	12,430					17
19 NONPHYSICIAN ANESTHETISTS	37,969					19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	326,432	159,012	145,646	41,037	250,670	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	119,323	89,542		23,108		50
53 ANESTHESIOLOGY	2,159	3,339		862		53
54 RADIOLOGY-DIAGNOSTIC	216,723	86,017		22,198		54
60 LABORATORY	234,175	24,456		6,311		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	717					62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	23,924					64
65 RESPIRATORY THERAPY	55,729	4,589		1,184		65
66 PHYSICAL THERAPY	101,119	46,879		12,098		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	15,846	4,589		1,184		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	26,523					71
72 IMPL. DEV. CHARGED TO PATIENT	18,813					72
73 DRUGS CHARGED TO PATIENTS	55,922					73
76 CARDIAC REHAB	13,991	5,335		1,377		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	426,642	160,150		41,332		88
90 CLINIC	1,012					90
90.01 PROVIDER BASED CLINIC	163	578		149		90.01
91 EMERGENCY	298,063	52,420		13,528		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	108,601	27,590		7,120		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						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,592,499	812,764	145,646	203,811	250,670	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	31,393	84,655		21,847		192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	4,718					192.03
192.04 RENTAL PROPERTIES	4,536			6,403		192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,633,146	897,419	145,646	232,061	250,670	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS + LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	14,492					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	495	299,609				13
14 CENTRAL SERVICES & SUPPLY	42		80,466			14
15 PHARMACY	360		441	646,632		15
16 MEDICAL RECORDS & LIBRARY	392		39		395,570	16
17 SOCIAL SERVICE	124	6,425				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,538	139,025	4,597		19,551	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	974	34,422	2,291		11,172	50
53 ANESTHESIOLOGY			82		6,117	53
54 RADIOLOGY-DIAGNOSTIC	651		8,082		84,174	54
60 LABORATORY	1,023		27,505		72,460	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	7				453	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	248				15,414	64
65 RESPIRATORY THERAPY	507		613		8,786	65
66 PHYSICAL THERAPY	125		962		31,827	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	165		239		6,310	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			15,187		8,356	71
72 IMPL. DEV. CHARGED TO PATIENT			14,113		2,478	72
73 DRUGS CHARGED TO PATIENTS				646,632	38,055	73
76 CARDIAC REHAB	133	6,937	101		1,334	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	3,761	23,822	1,593		33,304	88
90 CLINIC	10		128		442	90
90.01 PROVIDER BASED CLINIC	1		5		290	90.01
91 EMERGENCY	1,758	88,978	3,697		43,159	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,010		791		11,888	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						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	14,324	299,609	80,466	646,632	395,570	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	168					192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES						192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	14,492	299,609	80,466	646,632	395,570	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE 17	NONPHYSIC. ANESTHET. 19	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
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	76,189					17
19 NONPHYSICIAN ANESTHETISTS		212,729				19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	76,189		2,667,180		2,667,180	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM			830,043		830,043	50
53 ANESTHESIOLOGY		212,729	235,224		235,224	53
54 RADIOLOGY-DIAGNOSTIC			1,415,366		1,415,366	54
60 LABORATORY			1,443,775		1,443,775	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			4,477		4,477	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			149,700		149,700	64
65 RESPIRATORY THERAPY			327,915		327,915	65
66 PHYSICAL THERAPY			658,432		658,432	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY			101,268		101,268	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			172,145		172,145	71
72 IMPL. DEV. CHARGED TO PATIENT			121,995		121,995	72
73 DRUGS CHARGED TO PATIENTS			998,002		998,002	73
76 CARDIAC REHAB			93,607		93,607	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			2,654,350		2,654,350	88
90 CLINIC			6,250		6,250	90
90.01 PROVIDER BASED CLINIC			1,936		1,936	90.01
91 EMERGENCY			1,873,511		1,873,511	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES			656,860		656,860	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						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	76,189	212,729	14,412,036		14,412,036	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES			282,555		282,555	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT			26,436		26,436	192.03
192.04 RENTAL PROPERTIES			31,816		31,816	192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	76,189	212,729	14,752,843		14,752,843	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS 0	BLDGS & FIXTURES 1	MOVABLE EQUIPMENT 2		BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		2,347	3,653	6,000	6,000	4
5 ADMINISTRATIVE & GENERAL		41,930	65,269	107,199	1,084	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		71,804	111,778	183,582	147	7
8 LAUNDRY & LINEN SERVICE		4,631	7,209	11,840	7	8
9 HOUSEKEEPING		2,296	3,574	5,870	100	9
10 DIETARY		12,115	18,858	30,973	161	10
11 CAFETERIA					11	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		2,217	3,452	5,669	153	13
14 CENTRAL SERVICES & SUPPLY		7,899	12,295	20,194	13	14
15 PHARMACY		6,737	10,486	17,223	111	15
16 MEDICAL RECORDS & LIBRARY		8,724	13,580	22,304	121	16
17 SOCIAL SERVICE					38	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		47,853	74,488	122,341	786	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		26,947	41,946	68,893	301	50
53 ANESTHESIOLOGY		1,005	1,564	2,569		53
54 RADIOLOGY-DIAGNOSTIC		25,886	40,294	66,180	202	54
60 LABORATORY		7,360	11,456	18,816	317	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS					2	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					77	64
65 RESPIRATORY THERAPY		1,381	2,150	3,531	157	65
66 PHYSICAL THERAPY		14,108	21,960	36,068	39	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		1,381	2,150	3,531	51	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB		1,606	2,499	4,105	41	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		48,195	75,021	123,216	1,169	88
90 CLINIC					3	90
90.01 PROVIDER BASED CLINIC		174	271	445		90.01
91 EMERGENCY		15,775	24,556	40,331	544	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		8,303	12,924	21,227	313	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						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		360,674	561,433	922,107	5,948	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES		25,476	39,656	65,132	52	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES		7,466	11,622	19,088		192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		393,616	612,711	1,006,327	6,000	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL	108,283					5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	6,587	190,316				7
8 LAUNDRY & LINEN SERVICE	956	3,264	16,067			8
9 HOUSEKEEPING	1,647	1,618		9,235		9
10 DIETARY	1,468	8,537		413	41,552	10
11 CAFETERIA	106					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,127	1,563		76		13
14 CENTRAL SERVICES & SUPPLY	348	5,566		270		14
15 PHARMACY	4,533	4,747		230		15
16 MEDICAL RECORDS & LIBRARY	2,632	6,148		298		16
17 SOCIAL SERVICE	511					17
19 NONPHYSICIAN ANESTHETISTS	1,561					19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,423	33,722	16,067	1,633	41,552	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,907	18,989		920		50
53 ANESTHESIOLOGY	89	708		34		53
54 RADIOLOGY-DIAGNOSTIC	8,912	18,242		883		54
60 LABORATORY	9,629	5,186		251		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	29					62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	984					64
65 RESPIRATORY THERAPY	2,292	973		47		65
66 PHYSICAL THERAPY	4,158	9,942		481		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	652	973		47		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,091					71
72 IMPL. DEV. CHARGED TO PATIENT	774					72
73 DRUGS CHARGED TO PATIENTS	2,300					73
76 CARDIAC REHAB	575	1,131		55		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	17,548	33,963		1,646		88
90 CLINIC	42					90
90.01 PROVIDER BASED CLINIC	7	123		6		90.01
91 EMERGENCY	12,257	11,117		538		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	4,466	5,851		283		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						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	106,611	172,363	16,067	8,111	41,552	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	1,291	17,953		869		192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT	194					192.03
192.04 RENTAL PROPERTIES	187			255		192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	108,283	190,316	16,067	9,235	41,552	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA	NURSING	CENTRAL	PHARMACY	MEDICAL	
	11	ADMINIS- TRATION 13	SERVICES & SUPPLY 14	15	RECORDS + LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	117					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	4	9,592				13
14 CENTRAL SERVICES & SUPPLY			26,391			14
15 PHARMACY	3		145	26,992		15
16 MEDICAL RECORDS & LIBRARY	3		13		31,519	16
17 SOCIAL SERVICE	1	206				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	20	4,450	1,508		1,557	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	8	1,102	751		890	50
53 ANESTHESIOLOGY			27		487	53
54 RADIOLOGY-DIAGNOSTIC	5		2,651		6,715	54
60 LABORATORY	8		9,019		5,772	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS					36	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY	2				1,228	64
65 RESPIRATORY THERAPY	4		201		700	65
66 PHYSICAL THERAPY	1		316		2,535	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	1		78		503	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			4,981		666	71
72 IMPL. DEV. CHARGED TO PATIENT			4,629		197	72
73 DRUGS CHARGED TO PATIENTS				26,992	3,031	73
76 CARDIAC REHAB	1	222	33		106	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	33	763	523		2,653	88
90 CLINIC			42		35	90
90.01 PROVIDER BASED CLINIC			1		23	90.01
91 EMERGENCY	14	2,849	1,213		3,438	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	8		260		947	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	116	9,592	26,391	26,992	31,519	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	1					192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES						192.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	117	9,592	26,391	26,992	31,519	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE 17	NONPHYSIC. ANESTHET. 19	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
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	756				17
19 NONPHYSICIAN ANESTHETISTS		1,561			19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS	756		237,815		237,815 30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM			96,761		96,761 50
53 ANESTHESIOLOGY			3,914		3,914 53
54 RADIOLOGY-DIAGNOSTIC			103,790		103,790 54
60 LABORATORY			48,998		48,998 60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			67		67 62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY			2,291		2,291 64
65 RESPIRATORY THERAPY			7,905		7,905 65
66 PHYSICAL THERAPY			53,540		53,540 66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY			5,836		5,836 69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			6,738		6,738 71
72 IMPL. DEV. CHARGED TO PATIENT			5,600		5,600 72
73 DRUGS CHARGED TO PATIENTS			32,323		32,323 73
76 CARDIAC REHAB			6,269		6,269 76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)			181,514		181,514 88
90 CLINIC			122		122 90
90.01 PROVIDER BASED CLINIC			605		605 90.01
91 EMERGENCY			72,301		72,301 91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES			33,355		33,355 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					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	756		899,744		899,744 118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES			85,298		85,298 192
192.01 LIFELINE					192.01
192.02 HOME MEDICAL EQUIPMENT					192.02
192.03 COMMUNITY BENEFIT			194		194 192.03
192.04 RENTAL PROPERTIES			19,530		19,530 192.04
200 CROSS FOOT ADJUSTMENTS		1,561	1,561		1,561 200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	756	1,561	1,006,327		1,006,327 202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	
	1	2	4	5A	5	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	70,115					1
2 CAP REL COSTS-MVBLE EQUIP		70,115				2
4 EMPLOYEE BENEFITS	418	418	6,518,273			4
5 ADMINISTRATIVE & GENERAL	7,469	7,469	1,178,523	-2,633,146	12,119,697	5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	12,791	12,791	159,354		737,244	7
8 LAUNDRY & LINEN SERVICE	825	825	7,696		107,007	8
9 HOUSEKEEPING	409	409	109,106		184,374	9
10 DIETARY	2,158	2,158	174,893		164,323	10
11 CAFETERIA			11,959		11,905	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	395	395	166,682		238,111	13
14 CENTRAL SERVICES & SUPPLY	1,407	1,407	14,092		38,942	14
15 PHARMACY	1,200	1,200	120,989		507,424	15
16 MEDICAL RECORDS & LIBRARY	1,554	1,554	131,860		294,652	16
17 SOCIAL SERVICE			41,561		57,210	17
19 NONPHYSICIAN ANESTHETISTS					174,760	19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	8,524	8,524	854,105		1,502,483	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,800	4,800	327,608		549,211	50
53 ANESTHESIOLOGY	179	179			9,936	53
54 RADIOLOGY-DIAGNOSTIC	4,611	4,611	219,117		997,521	54
60 LABORATORY	1,311	1,311	344,088		1,077,845	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			2,501		3,300	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY			83,449		110,114	64
65 RESPIRATORY THERAPY	246	246	170,553		256,507	65
66 PHYSICAL THERAPY	2,513	2,513	42,190		465,422	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	246	246	55,544		72,935	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					122,079	71
72 IMPL. DEV. CHARGED TO PATIENT					86,591	72
73 DRUGS CHARGED TO PATIENTS					257,393	73
76 CARDIAC REHAB	286	286	44,874		64,399	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,585	8,585	1,265,656		1,963,746	88
90 CLINIC			3,530		4,658	90
90.01 PROVIDER BASED CLINIC	31	31	210		750	90.01
91 EMERGENCY	2,810	2,810	591,669		1,371,908	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,479	1,479	339,882		499,860	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)	64,247	64,247	6,461,691	-2,633,146	11,932,610	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,538	4,538	56,582		144,492	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT					21,718	192.03
192.04 RENTAL PROPERTIES	1,330	1,330			20,877	192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 08/22/2013 10:32

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT SQUARE FEET 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A	ADMINIS- TRATIVE & GENERAL ACCUM COST 5	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	393,616	612,711	2,082,865		2,633,146	202
203	UNIT COST MULT-WS B PT I	5.613863	8.738658	0.319542		0.217262	203
204	COST TO BE ALLOC PER B PT II			6,000		108,283	204
205	UNIT COST MULT-WS B PT II			0.000920		0.008934	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
	OF PLANT	& LINEN	KEEPING			
	SQUARE	SERVICE	SQUARE	PATIENT	GROSS	
	FEET	PATIENT	FEET	DAYS	SALARIES	
	7	DAYS	9	10	11	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	48,107					7
8 LAUNDRY & LINEN SERVICE	825	988				8
9 HOUSEKEEPING	409		48,203			9
10 DIETARY	2,158		2,158	988		10
11 CAFETERIA					4,876,742	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	395		395		166,682	13
14 CENTRAL SERVICES & SUPPLY	1,407		1,407		14,092	14
15 PHARMACY	1,200		1,200		120,989	15
16 MEDICAL RECORDS & LIBRARY	1,554		1,554		131,860	16
17 SOCIAL SERVICE					41,561	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	8,524	988	8,524	988	854,105	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	4,800		4,800		327,608	50
53 ANESTHESIOLOGY	179		179			53
54 RADIOLOGY-DIAGNOSTIC	4,611		4,611		219,117	54
60 LABORATORY	1,311		1,311		344,088	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS					2,501	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY					83,449	64
65 RESPIRATORY THERAPY	246		246		170,553	65
66 PHYSICAL THERAPY	2,513		2,513		42,190	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	246		246		55,544	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB	286		286		44,874	76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,585		8,585		1,265,656	88
90 CLINIC					3,530	90
90.01 PROVIDER BASED CLINIC	31		31		210	90.01
91 EMERGENCY	2,810		2,810		591,669	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	1,479		1,479		339,882	95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	43,569	988	42,335	988	4,820,160	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES	4,538		4,538		56,582	192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES			1,330			192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA
	SQUARE FEET 7	PATIENT DAYS 8	SQUARE FEET 9	PATIENT DAYS 10	GROSS SALARIES 11
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	897,419	145,646	232,061	250,670	14,492 202
203 UNIT COST MULT-WS B PT I	18.654645	147.414980	4.814244	253.714575	0.002972 203
204 COST TO BE ALLOC PER B PT II	190,316	16,067	9,235	41,552	117 204
205 UNIT COST MULT-WS B PT II	3.956098	16.262146	0.191586	42.056680	0.000024 205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION DIRECT NRSNG SALAR 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE PATIENT DAYS 17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5 ADMINISTRATIVE & GENERAL						5
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,938,176					13
14 CENTRAL SERVICES & SUPPLY		493,693				14
15 PHARMACY		2,707	709,920			15
16 MEDICAL RECORDS & LIBRARY		242		24,406,765		16
17 SOCIAL SERVICE	41,561				988	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	899,363	28,205		1,206,338	988	30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	222,674	14,056		689,302		50
53 ANESTHESIOLOGY		502		377,449		53
54 RADIOLOGY-DIAGNOSTIC		49,584		5,193,144		54
60 LABORATORY		168,753		4,470,906		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				27,970		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64 INTRAVENOUS THERAPY				951,062		64
65 RESPIRATORY THERAPY		3,762		542,083		65
66 PHYSICAL THERAPY		5,904		1,963,805		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		1,464		389,339		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		93,178		515,597		71
72 IMPL. DEV. CHARGED TO PATIENT		86,591		152,882		72
73 DRUGS CHARGED TO PATIENTS			709,920	2,348,041		73
76 CARDIAC REHAB	44,874	619		82,333		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	154,103	9,775		2,054,889		88
90 CLINIC		784		27,253		90
90.01 PROVIDER BASED CLINIC		28		17,907		90.01
91 EMERGENCY	575,601	22,683		2,662,984		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES		4,856		733,481		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)	1,938,176	493,693	709,920	24,406,765	988	118
NONREIMBURSABLE COST CENTERS						
192 PHYSICIANS' PRIVATE OFFICES						192
192.01 LIFELINE						192.01
192.02 HOME MEDICAL EQUIPMENT						192.02
192.03 COMMUNITY BENEFIT						192.03
192.04 RENTAL PROPERTIES						192.04

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NURSING ADMINIS- TRATION DIRECT NRSG SALAR 13	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 14	PHARMACY COSTED REQUIS. 15	MEDICAL RECORDS + LIBRARY GROSS REVENUE 16	SOCIAL SERVICE PATIENT DAYS 17	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	299,609	80,466	646,632	395,570	76,189	202
203	UNIT COST MULT-WS B PT I	0.154583	0.162988	0.910852	0.016207	77.114372	203
204	COST TO BE ALLOC PER B PT II	9,592	26,391	26,992	31,519	756	204
205	UNIT COST MULT-WS B PT II	0.004949	0.053456	0.038021	0.001291	0.765182	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NONPHYSIC. ANESTHET.	ASSIGNED TIME	
		19	
GENERAL SERVICE COST CENTERS			
1 CAP REL COSTS-BLDG & FIXT			1
2 CAP REL COSTS-MVBLE EQUIP			2
4 EMPLOYEE BENEFITS			4
5 ADMINISTRATIVE & GENERAL			5
6 MAINTENANCE & REPAIRS			6
7 OPERATION OF PLANT			7
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	100		19
20 NURSING SCHOOL			20
21 I&R SRVCES-SALARY & FRINGES APPRVD			21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			22
23 PARAMED ED PRGM-(SPECIFY)			23
INPATIENT ROUTINE SERV COST CENTERS			
ADULTS & PEDIATRICS			30
ANCILLARY SERVICE COST CENTERS			
50 OPERATING ROOM			50
53 ANESTHESIOLOGY	100		53
54 RADIOLOGY-DIAGNOSTIC			54
60 LABORATORY			60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			62.30
64 INTRAVENOUS THERAPY			64
65 RESPIRATORY THERAPY			65
66 PHYSICAL THERAPY			66
67 OCCUPATIONAL THERAPY			67
68 SPEECH PATHOLOGY			68
69 ELECTROCARDIOLOGY			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			71
72 IMPL. DEV. CHARGED TO PATIENT			72
73 DRUGS CHARGED TO PATIENTS			73
76 CARDIAC REHAB			76
76.97 CARDIAC REHABILITATION			76.97
76.98 HYPERBARIC OXYGEN THERAPY			76.98
76.99 LITHOTRIPSY			76.99
OUTPATIENT SERVICE COST CENTERS			
88 RURAL HEALTH CLINIC (RHC)			88
90 CLINIC			90
90.01 PROVIDER BASED CLINIC			90.01
91 EMERGENCY			91
92 OBSERVATION BEDS			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)	100		118
NONREIMBURSABLE COST CENTERS			
192 PHYSICIANS' PRIVATE OFFICES			192
192.01 LIFELINE			192.01
192.02 HOME MEDICAL EQUIPMENT			192.02
192.03 COMMUNITY BENEFIT			192.03
192.04 RENTAL PROPERTIES			192.04

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		NONPHYSIC. ANESTHET.	ASSIGNED TIME	
200	CROSS FOOT ADJUSTMENTS		19	200
201	NEGATIVE COST CENTER			201
202	COST TO BE ALLOC PER B PT I	212,729		202
203	UNIT COST MULT-WS B PT I	2,127.290000		203
204	COST TO BE ALLOC PER B PT II	1,561		204
205	UNIT COST MULT-WS B PT II	15.610000		205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
30 INPATIENT ROUTINE SERV COST CENTERS					
ADULTS & PEDIATRICS	2,667,180		2,667,180		30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	830,043		830,043		50
53 ANESTHESIOLOGY	235,224		235,224		53
54 RADIOLOGY-DIAGNOSTIC	1,415,366		1,415,366		54
60 LABORATORY	1,443,775		1,443,775		60
62 WHOLE BLOOD & PACKED RED BL	4,477		4,477		62
62.30 BLOOD CLOTTING FOR HEMOPHIL					62.30
64 INTRAVENOUS THERAPY	149,700		149,700		64
65 RESPIRATORY THERAPY	327,915		327,915		65
66 PHYSICAL THERAPY	658,432		658,432		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	101,268		101,268		69
71 MEDICAL SUPPLIES CHRGED TO	172,145		172,145		71
72 IMPL. DEV. CHARGED TO PATIE	121,995		121,995		72
73 DRUGS CHARGED TO PATIENTS	998,002		998,002		73
76 CARDIAC REHAB	93,607		93,607		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	2,654,350		2,654,350		88
90 CLINIC	6,250		6,250		90
90.01 PROVIDER BASED CLINIC	1,936		1,936		90.01
91 EMERGENCY	1,873,511		1,873,511		91
92 OBSERVATION BEDS	560,353		560,353		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES	656,860		656,860		95
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THE					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
113 INTEREST EXPENSE					113
200 SUBTOTAL (SEE INSTRUCTIONS)	14,972,389		14,972,389		200
201 LESS OBSERVATION BEDS	560,353		560,353		201
202 TOTAL (SEE INSTRUCTIONS)	14,412,036		14,412,036		202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
30 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	961,849		961,849			30
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	59,514	629,788	689,302	1.204179		50
53 ANESTHESIOLOGY	33,625	343,824	377,449	0.623194		53
54 RADIOLOGY-DIAGNOSTIC	403,788	4,789,356	5,193,144	0.272545		54
60 LABORATORY	439,058	4,031,848	4,470,906	0.322927		60
62 WHOLE BLOOD & PACKED RED BL	1,665	26,305	27,970	0.160064		62
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
64 INTRAVENOUS THERAPY	28,697	922,365	951,062	0.157403		64
65 RESPIRATORY THERAPY	276,641	265,442	542,083	0.604917		65
66 PHYSICAL THERAPY	36,906	1,926,899	1,963,805	0.335284		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	43,704	345,635	389,339	0.260102		69
71 MEDICAL SUPPLIES CHRGD TO	233,786	281,811	515,597	0.333875		71
72 IMPL. DEV. CHARGED TO PATIE	10,842	142,040	152,882	0.797968		72
73 DRUGS CHARGED TO PATIENTS	980,742	1,367,299	2,348,041	0.425036		73
76 CARDIAC REHAB		82,333	82,333	1.136932		76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	176,450	1,878,439	2,054,889			88
90 CLINIC	2,039	25,214	27,253	0.229333		90
90.01 PROVIDER BASED CLINIC		17,907	17,907	0.108114		90.01
91 EMERGENCY	26,150	2,636,834	2,662,984	0.703538		91
92 OBSERVATION BEDS	9,707	234,782	244,489	2.291935		92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES	8,408	725,073	733,481	0.895538		95
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	3,733,571	20,673,194	24,406,765			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)		20,673,194	24,406,765			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1.204179		127,061			153,004	50
53 ANESTHESIOLOGY	0.623194		71,249			44,402	53
54 RADIOLOGY-DIAGNOSTIC	0.272545		1,786,118			486,798	54
60 LABORATORY	0.322927		1,734,876			560,238	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.160064		18,268			2,924	62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	0.157403		433,261			68,197	64
65 RESPIRATORY THERAPY	0.604917		131,198			79,364	65
66 PHYSICAL THERAPY	0.335284		648,884			217,560	66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.260102		162,821			42,350	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.333875		79,778			26,636	71
72 IMPL. DEV. CHARGED TO PATIENT	0.797968		9,878			7,882	72
73 DRUGS CHARGED TO PATIENTS	0.425036		674,033			286,488	73
76 CARDIAC REHAB	1.136932		51,519			58,574	76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
90 CLINIC	0.229333		16,498			3,784	90
90.01 PROVIDER BASED CLINIC	0.108114		4,709			509	90.01
91 EMERGENCY	0.703538		740,696			521,108	91
92 OBSERVATION BEDS	2.291935		135,827			311,307	92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.895538						95
200 SUBTOTAL (SEE INSTRUCTIONS)			6,826,674			2,871,125	200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)			6,826,674			2,871,125	202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-Z303)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1.204179						50
53 ANESTHESIOLOGY	0.623194						53
54 RADIOLOGY-DIAGNOSTIC	0.272545						54
60 LABORATORY	0.322927						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.160064						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	0.157403						64
65 RESPIRATORY THERAPY	0.604917						65
66 PHYSICAL THERAPY	0.335284						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.260102						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.333875						71
72 IMPL. DEV. CHARGED TO PATIENT	0.797968						72
73 DRUGS CHARGED TO PATIENTS	0.425036						73
76 CARDIAC REHAB	1.136932						76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
90 CLINIC	0.229333						90
90.01 PROVIDER BASED CLINIC	0.108114						90.01
91 EMERGENCY	0.703538						91
92 OBSERVATION BEDS	2.291935						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.895538						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	(COL.1 MINUS COL.2)	(COL.3 ÷ COL.4)		(COL.5 x COL.6)
	1	2	3	5	6	7
INPAT ROUTINE SERV COST CTRS						
30 ADULTS & PEDIATRICS	237,815	16,451	221,364	1,276	173.48	24
31 INTENSIVE CARE UNIT						4,164
32 CORONARY CARE UNIT						30
33 BURN INTENSIVE CARE UNIT						32
34 SURGICAL INTENSIVE CARE UNIT						33
35 OTHER SPECIAL CARE (SPECIFY)						34
40 SUBPROVIDER - IPF						35
41 SUBPROVIDER - IRF						40
42 SUBPROVIDER I						41
43 NURSERY						42
44 SKILLED NURSING FACILITY						43
45 NURSING FACILITY						44
200 TOTAL (LINES 30-199)	237,815		221,364	1,276		24
						4,164
						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK [] TITLE V [XX] HOSPITAL (14-1303) [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII-PT A [] IPF
 BOXES [XX] TITLE XIX [] IRF

[] PPS
 [] TEFRA
 [XX] OTHER

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	96,761	689,302	0.140375		50
53 ANESTHESIOLOGY	3,914	377,449	0.010370		53
54 RADIOLOGY-DIAGNOSTIC	103,790	5,193,144	0.019986		54
60 LABORATORY	48,998	4,470,906	0.010959		60
62 WHOLE BLOOD & PACKED RED BLOO	67	27,970	0.002395		62
62.30 BLOOD CLOTTING FOR HEMOPHILIA					62.30
64 INTRAVENOUS THERAPY	2,291	951,062	0.002409		64
65 RESPIRATORY THERAPY	7,905	542,083	0.014583		65
66 PHYSICAL THERAPY	53,540	1,963,805	0.027263		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	5,836	389,339	0.014990		69
71 MEDICAL SUPPLIES CHRGED TO PA	6,738	515,597	0.013068		71
72 IMPL. DEV. CHARGED TO PATIENT	5,600	152,882	0.036630		72
73 DRUGS CHARGED TO PATIENTS	32,323	2,348,041	0.013766		73
76 CARDIAC REHAB	6,269	82,333	0.076142		76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	181,514	2,054,889	0.088333		88
90 CLINIC	122	27,253	0.004477		90
90.01 PROVIDER BASED CLINIC	605	17,907	0.033786		90.01
91 EMERGENCY	72,301	2,662,984	0.027150		91
92 OBSERVATION BEDS	53,676	244,489	0.219544		92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-199)	682,250	22,711,435			200

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					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 (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	1,276		24		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 (SUM OF LINES 30-199)	1,276		24		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			HEALTH	MEDICAL	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY	212,729				212,729	53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62 WHOLE BLOOD & PACKED RED BLOO						62
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
64 INTRAVENOUS THERAPY						64
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB						76
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
90 CLINIC						90
90.01 PROVIDER BASED CLINIC						90.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
95 AMBULANCE SERVICES						95
200 TOTAL (SUM OF LINES 50-199)	212,729				212,729	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [XX] OTHER

COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	689,302						50
53 ANESTHESIOLOGY	377,449	0.563597					53
54 RADIOLOGY-DIAGNOSTIC	5,193,144						54
60 LABORATORY	4,470,906						60
62 WHOLE BLOOD & PACKED RED BLO	27,970						62
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30
64 INTRAVENOUS THERAPY	951,062						64
65 RESPIRATORY THERAPY	542,083						65
66 PHYSICAL THERAPY	1,963,805						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	389,339						69
71 MEDICAL SUPPLIES CHRGED TO P	515,597						71
72 IMPL. DEV. CHARGED TO PATIEN	152,882						72
73 DRUGS CHARGED TO PATIENTS	2,348,041						73
76 CARDIAC REHAB	82,333						76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)	2,054,889						88
90 CLINIC	27,253						90
90.01 PROVIDER BASED CLINIC	17,907						90.01
91 EMERGENCY	2,662,984						91
92 OBSERVATION BEDS	244,489						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	733,481						95
200 TOTAL (SUM OF LINES 50-199)	22,711,435						200

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO		COST REIMB.	COST REIMB.	COST	COST	
	CHARGE RATIO	PPS	SERVICES	SVCES NOT	SERVICES	SVCES NOT	
	FROM WKST C,	REIMBURSED	SUBJECT TO	SUBJECT TO	PPS	SUBJECT TO	SUBJECT TO
	PT I, COL. 9	SERVICES	DED & COINS	DED & COINS	SERVICES	DED & COINS	DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	1.204179						50
53 ANESTHESIOLOGY	0.623194						53
54 RADIOLOGY-DIAGNOSTIC	0.272545						54
60 LABORATORY	0.322927						60
62 WHOLE BLOOD & PACKED RED BLOOD	0.160064						62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64 INTRAVENOUS THERAPY	0.157403						64
65 RESPIRATORY THERAPY	0.604917						65
66 PHYSICAL THERAPY	0.335284						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.260102						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.333875						71
72 IMPL. DEV. CHARGED TO PATIENT	0.797968						72
73 DRUGS CHARGED TO PATIENTS	0.425036						73
76 CARDIAC REHAB	1.136932						76
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
90 CLINIC	0.229333						90
90.01 PROVIDER BASED CLINIC	0.108114						90.01
91 EMERGENCY	0.703538						91
92 OBSERVATION BEDS	2.291935						92
OTHER REIMBURSABLE COST CENTERS							
95 AMBULANCE SERVICES	0.895538						95
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,383	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,276	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	978	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	63	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)	31	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	9	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	4	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	728	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)	63	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)	31	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	12	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	13	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	14	
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	15	
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	16	
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	18	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	131.13	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,667,180	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)	1,086	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	525	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	184,504	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,482,676	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	889,195	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	10,311	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	878,884	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.792049	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	1,031.10	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	898.65	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	132.45	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	369.81	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	3,698	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,478,978	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,942.77 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,414,337 39
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 1,414,337 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					656,623 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					2,070,960 49

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

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

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) 122,395 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 60,226 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 182,621 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 288 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,945.67 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 560,353 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	237,815	2,482,676	0.095790	560,353	53,676 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	1,383	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	1,276	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	10	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	978	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	63	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)	31	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	9	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	4	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	24	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 TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	131.13	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,667,180	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)	1,086	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	525	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	184,504	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,482,676	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	889,195	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	10,311	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	878,884	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	2.792049	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	1,031.10	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	898.65	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	132.45	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	369.81	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	3,698	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,478,978	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,942.77 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 46,626 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) 46,626 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5
42 NURSERY (TITLES V AND XIX ONLY)					42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT					43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					46,626 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 4,164 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 4,164 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 288 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

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

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		643,507			30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1.204179	19,385	23,343		50
53 ANESTHESIOLOGY	0.623194	9,250	5,765		53
54 RADIOLOGY-DIAGNOSTIC	0.272545	256,851	70,003		54
60 LABORATORY	0.322927	294,282	95,032		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.160064	776	124		62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY	0.157403	402	63		64
65 RESPIRATORY THERAPY	0.604917	178,884	108,210		65
66 PHYSICAL THERAPY	0.335284	21,820	7,316		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.260102	28,589	7,436		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.333875	161,947	54,070		71
72 IMPL. DEV. CHARGED TO PATIENT	0.797968	513	409		72
73 DRUGS CHARGED TO PATIENTS	0.425036	667,745	283,816		73
76 CARDIAC REHAB	1.136932				76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
90 CLINIC	0.229333	1,943	446		90
90.01 PROVIDER BASED CLINIC	0.108114				90.01
91 EMERGENCY	0.703538	838	590		91
92 OBSERVATION BEDS	2.291935				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,643,225	656,623		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,643,225			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z303) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1.204179				50
53 ANESTHESIOLOGY	0.623194				53
54 RADIOLOGY-DIAGNOSTIC	0.272545	3,687	1,005		54
60 LABORATORY	0.322927	9,441	3,049		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.160064				62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
64 INTRAVENOUS THERAPY	0.157403				64
65 RESPIRATORY THERAPY	0.604917	22,995	13,910		65
66 PHYSICAL THERAPY	0.335284	8,970	3,007		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.260102				69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.333875	9,753	3,256		71
72 IMPL. DEV. CHARGED TO PATIENT	0.797968				72
73 DRUGS CHARGED TO PATIENTS	0.425036	80,677	34,291		73
76 CARDIAC REHAB	1.136932				76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
90 CLINIC	0.229333				90
90.01 PROVIDER BASED CLINIC	0.108114				90.01
91 EMERGENCY	0.703538	1,674	1,178		91
92 OBSERVATION BEDS	2.291935				92
OTHER REIMBURSABLE COST CENTERS					
95 AMBULANCE SERVICES					95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		137,197	59,696		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		137,197			202

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 08/22/2013 10:32

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1303) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	1.204179			50
53 ANESTHESIOLOGY	0.623194			53
54 RADIOLOGY-DIAGNOSTIC	0.272545			54
60 LABORATORY	0.322927			60
62 WHOLE BLOOD & PACKED RED BLOOD	0.160064			62
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64 INTRAVENOUS THERAPY	0.157403			64
65 RESPIRATORY THERAPY	0.604917			65
66 PHYSICAL THERAPY	0.335284			66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.260102			69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.333875			71
72 IMPL. DEV. CHARGED TO PATIENT	0.797968			72
73 DRUGS CHARGED TO PATIENTS	0.425036			73
76 CARDIAC REHAB	1.136932			76
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.229333			90
90.01 PROVIDER BASED CLINIC	0.108114			90.01
91 EMERGENCY	0.703538			91
92 OBSERVATION BEDS	2.291935			92
OTHER REIMBURSABLE COST CENTERS				
95 AMBULANCE SERVICES				95
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] HOSPITAL (14-1303) [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY		AMOUNT	
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,030,687		2,132,715
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.			10/22/2012	5,284
PROGRAM .01		NONE		3.01
TO .02				3.02
PROVIDER .03				3.03
TO .04				3.04
PROVIDER .05				3.05
.06				3.06
.07				3.07
.08				3.08
.09				3.09
.50	10/22/2012	27,812		3.50
.51	11/07/2012	60,815	11/07/2012	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
.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-88,627		-83,305
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		1,942,060		2,049,410

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.				
PROGRAM .01		NONE		NONE
TO .02				5.01
PROVIDER .03				5.02
.04				5.03
.05				5.04
.06				5.05
.07				5.06
.08				5.07
.09				5.08
PROVIDER .50		NONE		5.09
TO .51				5.50
PROGRAM .52				5.51
.53				5.52
.54				5.53
.55				5.54
.56				5.55
.57				5.56
.58				5.57
.59				5.58
.99				5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT				
PROGRAM .01		35,052		30,591
TO .02				6.01
PROVIDER .03				6.02
PROVIDER .04				6.03
TO .05				6.04
PROGRAM .06				6.05
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		1,977,112		2,080,001
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER) INPATIENT
 APPLICABLE [] IPF [] SNF PART A PART B
 BOX: [] IRF [XX] SWING BED SNF (14-Z303)

DESCRIPTION	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		249,964		1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		3.01
PROGRAM .01				3.02
TO .02				3.03
PROVIDER .03				3.04
TO .04				3.05
PROVIDER .05				3.06
TO .06				3.07
PROVIDER .07				3.08
TO .08				3.09
PROVIDER .09				3.50
TO .50	10/22/2012	2,217		NONE
PROVIDER .51				3.51
TO .52				3.52
PROVIDER .53				3.53
TO .54				3.54
PROVIDER .55				3.55
TO .56				3.56
PROVIDER .57				3.57
TO .58				3.58
PROVIDER .59				3.59
TO .99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-2,217		
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		247,747		4
TO BE COMPLETED BY CONTRACTOR				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
PROGRAM .01				5.01
TO .02				5.02
PROVIDER .03				5.03
TO .04				5.04
PROVIDER .05				5.05
TO .06				5.06
PROVIDER .07				5.07
TO .08				5.08
PROVIDER .09				5.09
TO .50				5.50
PROVIDER .51		NONE		NONE
TO .52				5.51
PROVIDER .53				5.52
TO .54				5.53
PROVIDER .55				5.54
TO .56				5.55
PROVIDER .57				5.56
TO .58				5.57
PROVIDER .59				5.58
TO .99				5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT				6.01
PROGRAM .01				6.01
TO .02				6.02
PROVIDER .03				6.02
TO .04				6.02
PROVIDER .05				6.02
TO .06				6.02
PROVIDER .07				6.02
TO .08				6.02
PROVIDER .09				6.02
TO .10				6.02
PROVIDER .11				6.02
TO .12				6.02
PROVIDER .13				6.02
TO .14				6.02
PROVIDER .15				6.02
TO .16				6.02
PROVIDER .17				6.02
TO .18				6.02
PROVIDER .19				6.02
TO .20				6.02
PROVIDER .21				6.02
TO .22				6.02
PROVIDER .23				6.02
TO .24				6.02
PROVIDER .25				6.02
TO .26				6.02
PROVIDER .27				6.02
TO .28				6.02
PROVIDER .29				6.02
TO .30				6.02
PROVIDER .31				6.02
TO .32				6.02
PROVIDER .33				6.02
TO .34				6.02
PROVIDER .35				6.02
TO .36				6.02
PROVIDER .37				6.02
TO .38				6.02
PROVIDER .39				6.02
TO .40				6.02
PROVIDER .41				6.02
TO .42				6.02
PROVIDER .43				6.02
TO .44				6.02
PROVIDER .45				6.02
TO .46				6.02
PROVIDER .47				6.02
TO .48				6.02
PROVIDER .49				6.02
TO .50				6.02
PROVIDER .51				6.02
TO .52				6.02
PROVIDER .53				6.02
TO .54				6.02
PROVIDER .55				6.02
TO .56				6.02
PROVIDER .57				6.02
TO .58				6.02
PROVIDER .59				6.02
TO .60				6.02
PROVIDER .61				6.02
TO .62				6.02
PROVIDER .63				6.02
TO .64				6.02
PROVIDER .65				6.02
TO .66				6.02
PROVIDER .67				6.02
TO .68				6.02
PROVIDER .69				6.02
TO .70				6.02
PROVIDER .71				6.02
TO .72				6.02
PROVIDER .73				6.02
TO .74				6.02
PROVIDER .75				6.02
TO .76				6.02
PROVIDER .77				6.02
TO .78				6.02
PROVIDER .79				6.02
TO .80				6.02
PROVIDER .81				6.02
TO .82				6.02
PROVIDER .83				6.02
TO .84				6.02
PROVIDER .85				6.02
TO .86				6.02
PROVIDER .87				6.02
TO .88				6.02
PROVIDER .89				6.02
TO .90				6.02
PROVIDER .91				6.02
TO .92				6.02
PROVIDER .93				6.02
TO .94				6.02
PROVIDER .95				6.02
TO .96				6.02
PROVIDER .97				6.02
TO .98				6.02
PROVIDER .99				6.02
TO .01				6.02
PROVIDER .02				6.02
TO .03				6.02
PROVIDER .04				6.02
TO .05				6.02
PROVIDER .06				6.02
TO .07				6.02
PROVIDER .08				6.02
TO .09				6.02
PROVIDER .10				6.02
TO .11				6.02
PROVIDER .12				6.02
TO .13				6.02
PROVIDER .14				6.02
TO .15				6.02
PROVIDER .16				6.02
TO .17				6.02
PROVIDER .18				6.02
TO .19				6.02
PROVIDER .20				6.02
TO .21				6.02
PROVIDER .22				6.02
TO .23				6.02
PROVIDER .24				6.02
TO .25				6.02
PROVIDER .26				6.02
TO .27				6.02
PROVIDER .28				6.02
TO .29				6.02
PROVIDER .30				6.02
TO .31				6.02
PROVIDER .32				6.02
TO .33				6.02
PROVIDER .34				6.02
TO .35				6.02
PROVIDER .36				6.02
TO .37				6.02
PROVIDER .38				6.02
TO .39				6.02
PROVIDER .40				6.02
TO .41				6.02
PROVIDER .42				6.02
TO .43				6.02
PROVIDER .44				6.02
TO .45				6.02
PROVIDER .46				6.02
TO .47				6.02
PROVIDER .48				6.02
TO .49				6.02
PROVIDER .50				6.02
TO .51				6.02
PROVIDER .52				6.02
TO .53				6.02
PROVIDER .54				6.02
TO .55				6.02
PROVIDER .56				6.02
TO .57				6.02
PROVIDER .58				6.02
TO .59				6.02
PROVIDER .60				6.02
TO .61				6.02
PROVIDER .62				6.02
TO .63				6.02
PROVIDER .64				6.02
TO .65				6.02
PROVIDER .66				6.02
TO .67				6.02
PROVIDER .68				6.02
TO .69				6.02
PROVIDER .70				6.02
TO .71				6.02
PROVIDER .72				6.02
TO .73				6.02
PROVIDER .74				6.02
TO .75				6.02
PROVIDER .76				6.02
TO .77				6.02
PROVIDER .78				6.02
TO .79				6.02
PROVIDER .80				6.02
TO .81				6.02
PROVIDER .82				6.02
TO .83				6.02
PROVIDER .84				6.02
TO .85				6.02
PROVIDER .86				6.02
TO .87				6.02
PROVIDER .88				6.02
TO .89				6.02
PROVIDER .90				6.02
TO .91				6.02
PROVIDER .92				6.02
TO .93				6.02
PROVIDER .94				6.02
TO .95				6.02
PROVIDER .96				6.02
TO .97				6.02
PROVIDER .98				6.02
TO .99				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		243,345		7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:	8

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1303) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	263	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	728	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	128	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	988	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	24,406,765	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	309,871	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)		8

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

PROVIDER CCN: 14-1303 DR JOHN WARNER HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z303)
APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	184,447	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	60,293	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	94	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	244,740	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	244,740	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	244,740	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	1,395	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	243,345	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	243,345	19
20 INTERIM PAYMENTS	247,747	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	-4,402	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART V

CHECK [XX] HOSPITAL (14-1303)
 APPLICABLE BOX: [] SUB (OTHER)

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

1	INPATIENT SERVICES	2,070,960	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	2,070,960	4
5	PRIMARY PAYER PAYMENTS	361	5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	2,091,309	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6 AND 17)	2,091,309	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	141,680	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	1,949,629	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	1,949,629	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	27,483	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	27,483	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	27,483	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	1,977,112	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	1,977,112	30
31	INTERIM PAYMENTS	1,942,060	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	35,052	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-1303) [] SNF [] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [XX] OTHER
 [] SUB (OTHER)

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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX
COMPUTATION OF NET COST OF COVERED SERVICES		
1	46,626	1
2		2
3		3
4	46,626	4
5		5
6		6
7	46,626	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES		
8		8
9		9
10		10
11		11
12		12
CUSTOMARY CHARGES		
13		13
14		14
15		15
16		16
17		17
18		18
19		19
20		20
21	46,626	21
PROSPECTIVE PAYMENT AMOUNT		
22		22
23		23
24		24
25		25
26		26
27		27
28		28
29	46,626	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30		30
31	46,626	31
32		32
33		33
34		34
35		35
36	46,626	36
37		37
38	46,626	38
39		39
40	46,626	40
41		41
42	46,626	42
43		43

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,239,371			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	5,114,778			4
5	OTHER RECEIVABLES	236,000			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,596,911			6
7	INVENTORY	323,459			7
8	PREPAID EXPENSES	384,470			8
9	OTHER CURRENT ASSETS				9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	4,701,167			11
FIXED ASSETS					
12	LAND	343,588			12
13	LAND IMPROVEMENTS				13
14	ACCUMULATED DEPRECIATION				14
15	BUILDINGS	10,513,203			15
16	ACCUMULATED DEPRECIATION	-6,733,020			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	133,362			19
20	ACCUMULATED DEPRECIATION	-57,873			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	4,581,061			23
24	ACCUMULATED DEPRECIATION	-3,777,759			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	5,002,562			30
OTHER ASSETS					
31	INVESTMENTS	436,392			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	308,760			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	745,152			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	10,448,881			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	651,353			37
38	SALARIES, WAGES & FEES PAYABLE	731,888			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	235,000			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS				43
44	OTHER CURRENT LIABILITIES	243,633			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	1,861,874			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE				46
47	NOTES PAYABLE	840,000			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	840,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	2,701,874			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	7,747,007			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	7,747,007			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	10,448,881			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		7,890,388							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		-149,900							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		7,740,488							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5 CAPITAL GRANTS		6,923							5
6 UNREALIZED GAIN		-404							6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)		6,519							10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		7,747,007							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13 UNREALIZED LOSS									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)		7,747,007							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	981,572		981,572	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	981,572		981,572	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	981,572		981,572	18
19 ANCILLARY SERVICES	2,632,054		2,632,054	19
20 OUTPATIENT SERVICES		20,224,924	20,224,924	20
21 RHC	176,450	2,014,126	2,190,576	21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE	8,408	725,073	733,481	25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	3,798,484	22,964,123	26,762,607	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		16,153,736	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 INTEREST EXPENSE	-56,830		38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)		-56,830	42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		16,096,906	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	26,762,607	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	11,594,860	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	15,167,747	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	16,096,906	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-929,159	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	68,369	6
7	INCOME FROM INVESTMENTS	14,732	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	14,607	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	5,500	15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	1,112	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	987	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	8,803	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,256	21
22	RENTAL OF HOSPITAL SPACE	25,758	22
23	GOVERNMENTAL APPROPRIATIONS	250,539	23
24	OTHER (OTHER DIETARY REVENUE)	259,392	24
24.01	OTHER (SALE: MINOR EQUIPMENT/SUPPLIES)	23,698	24.01
24.02	OTHER (FITNESS CENTER)	9,621	24.02
24.03	OTHER (PHARM 340B RETAIL/CONTRACT REV)	109,679	24.03
24.04	OTHER (MISC OTHER)	11,087	24.04
24.05	OTHER (GAIN(LOSS) SALE/DISPOSE ASSET)	32,738	24.05
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	837,878	25
26	TOTAL (LINE 5 PLUS LINE 25)	-91,281	26
27	OTHER EXPENSES (INTEREST EXPENSE)	56,830	27
27.01	OTHER EXPENSES (RENTAL EXPENSE)	1,789	27.01
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	58,619	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	-149,900	29

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	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
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5 ADMINISTRATIVE & GENERAL					5
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
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 SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
30 INPATIENT ROUTINE SERV COST CENTERS					30
ADULTS & PEDIATRICS					
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62 WHOLE BLOOD & PACKED RED BLOOD					62
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
64 INTRAVENOUS THERAPY					64
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIAC REHAB					76
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC (RHC)					88
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 PROVIDER BASED CLINIC					90.01
91 EMERGENCY					91
92 OBSERVATION BEDS					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 THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 LIFELINE					192.01
192.02 HOME MEDICAL EQUIPMENT					192.02
192.03 COMMUNITY BENEFIT					192.03
192.04 RENTAL PROPERTIES					192.04
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

RHC I
 COMPONENT NO: 14-3404

WORKSHEET M-1

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

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	828,680		828,680	-190,179	638,501	-52,765	585,736	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	160,102		160,102		160,102		160,102	3
4 VISITING NURSE								4
5 OTHER NURSE	148,524		148,524		148,524		148,524	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER		38,020	38,020		38,020		38,020	7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	318,529		318,529		318,529		318,529	9
10 SUBTOTAL (SUM OF LINES 1-9)	1,455,835	38,020	1,493,855	-190,179	1,303,676	-52,765	1,250,911	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT		12,747	12,747		12,747		12,747	11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT		35,175	35,175		35,175		35,175	13
14 SUBTOTAL (SUM OF LINES 11-13)		47,922	47,922		47,922		47,922	14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		62,657	62,657		62,657		62,657	15
16 TRANSPORTATION (HEALTH CARE STAFF)		5,883	5,883		5,883		5,883	16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE		116,840	116,840	-116,840				18
19 OTHER HEALTH CARE COSTS		30,213	30,213	-3,906	26,307		26,307	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		215,593	215,593	-120,746	94,847		94,847	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	1,455,835	301,535	1,757,370	-310,925	1,446,445	-52,765	1,393,680	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS				-3,024	-3,024		-3,024	26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				-3,024	-3,024		-3,024	28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS		49,557	49,557		49,557	-4,117	45,440	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)		49,557	49,557		49,557	-4,117	45,440	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,455,835	351,092	1,806,927	-313,949	1,492,978	-56,882	1,436,096	32

RHC I
 COMPONENT NO: 14-3404

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	2.11	7,927	4,200	8,862	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.97	3,078	2,100	2,037	3
4	SUBTOTAL (SUM OF LINES 1-3)	3.08	11,005		10,899	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER		99			7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	3.08	11,104			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		16			9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				1,393,680	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)				-3,024	11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				1,390,656	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.002175	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				45,440	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				1,218,254	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				1,263,694	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				1,263,694	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				1,266,443	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				2,660,123	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES
 RHC I COMPONENT NO: 14-3404

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	2,660,123	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	11,777	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	2,648,346	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	11,104	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)	16	5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	11,120	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	238.16	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)	78.07	78.54	8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	238.16	238.16	238.16 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	2,906	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	692,093	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	99	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	23,578	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	19,157	14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	711,250	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)	499,755	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)	906	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	1,289	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	534,547	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	535,836	16.05
17	PRIMARY PAYOR PAYMENTS	153	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)	41,777	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	95,385	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	535,683	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	3,252	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	538,935	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	21,656	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	21,489	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	560,591	26
27	INTERIM PAYMENTS	473,351	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	87,240	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		30

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

RHC I
 COMPONENT NO: 14-3404

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	1,250,911	1,250,911	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000100	0.001780	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	125	2,227	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	903	2,921	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	1,028	5,148	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	1,393,680	1,393,680	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,263,694	1,263,694	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000738	0.003694	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	933	4,668	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,961	9,816	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	15	272	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	130.73	36.09	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	5	72	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	654	2,598	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		11,777	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)		3,252	16

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

RHC I
 COMPONENT NO: 14-3404

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		489,879	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 PROGRAM .03 TO .04 PROVIDER .05 .06 .07 .08 .09 .50 .51 PROVIDER .52 TO .53 PROGRAM .54 .55 .56 .57 .58 .59 .99	NONE	3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	10/22/2012	16,528	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		-16,528	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 .04 .05 .06 .07 .08 .09 PROVIDER .50 TO .51 PROGRAM .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE	5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)		NONE	
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01 PROVIDER PROVIDER TO .02 PROGRAM	87,240	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		560,591	7
8 NAME OF CONTRACTOR: _____	CONTRACTOR NUMBER: _____	NPR DATE: _____	8