

MARSHALL BROWNING HOSPITAL

DUQUOIN, ILLINOIS

MEDICARE COST REPORT

YEAR ENDED JUNE 30, 2014

November 24, 2014

Wisconsin Physicians Service
P.O. Box 8310
Omaha, NE 68108-0310

Re: Provider: Marshall Browning Hospital
Provider Numbers: 14-1331, 14-Z331, 14-8504
Period ended: 6-30-14
Protested amount claimed on submitted cost report.

Dear Sir or Madam:

The cost report for Marshall Browning Hospital, for the year ended June 30, 2014, claims additional amounts due the provider for an expense paid by the provider, but currently not classified as a reimbursable cost by Wisconsin Physicians Service. The expense in question relates to the provider tax assessment in the amount of \$279,420, which we have included as an adjustment to line 5.00 (Administrative and General) on worksheet A-8. We feel as though the expense should be allowed as a reimbursable cost under Medicare Guidelines.

The calculation of the additional amounts due the provider was calculated by removing the adjustment on worksheet A-8. The protested amounts claimed for the period ended June 30, 2014 are as follows:

Worksheet E, part B, line 44	\$ 53,449
Worksheet E-2, line 23	32,558
Worksheet E-3, part V, line 34	37,245
Worksheet M-3, line 30	<u>5,628</u>
Total	<u>\$ 128,880</u>

Sincerely,

Edwin Gast, CEO
Marshall Browning Hospital
900 North Washington Street
Duquoin, Illinois 62832
(618)542-2146

Optimizer Systems, Inc.

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Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:33 Version: 2014.10
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 11/24/2014	TIME: 10:33
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY MARSHALL BROWNING HOSPITAL (14-1331) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 07/01/2013 AND ENDING 06/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/24/2014 10:33
AH0.aw4HA5foqoBS7JO8LTLcCqQz0
0xILg0Te3PyVkcFBrIqlyjdc:0v3K
vFw204Ja4H0syG:g

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

PI Encryption: 11/24/2014 10:33
PN7SA5.0i1du2sUDeyoBySb0SOFJe0
8p:hH017TGatYQvmGzIKyE9ULGJpq2
rmCO0XBbfq0oifjs

TITLE

DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII			
	TITLE V	PART A	PART B	HIT	TITLE XIX
	1	2	3	4	5
1	HOSPITAL	139,259	94,275	1,518,481	1
2	SUBPROVIDER - IPF				2
3	SUBPROVIDER - IRF				3
4	SUBPROVIDER (OTHER)				4
5	SWING BED - SNF	162,392			5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	HOME HEALTH AGENCY				9
10	HEALTH CLINIC - RHC		4,119		10
11	HEALTH CLINIC - FQHC				11
12	OUTPATIENT REHABILITATION PROVIDER				12
200	TOTAL	301,651	98,394	1,518,481	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.

Optimizer Systems, Inc.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:										
1	Street: 900 NORTH WASHINGTON STREET	P.O. Box:							1	
2	City: DUQUOIN	State: IL	ZIP Code: 62832	County: PERRY					2	
Hospital and Hospital-Based Component Identification:										
Payment System (P, T, O, or N)										
Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX		
0	1	2	3	4	5	6	7	8	3	
3	Hospital	MARSHALL BROWNING HOSPITAL	14-1331	99914	1	01/01/2004	N	O	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	MARSHALL BROWNING SWING BED	14-2331	99914		01/01/2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	MARSHALL BROWNING PHYSICIAN CLINIC	14-8504	99914		05/01/2009	N	O	N	15
16	Hospital-Based Health Clinic - FOHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2013	To: 06 / 30 / 2014							20
21	Type of control (see instructions)	2								21
Inpatient PPS Information										
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickie amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.							1	2	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)							N	N	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.							3	N	23
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
		1	2	3	4	5	6			
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									25
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.			2					26	
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.			2					27	
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35		
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			Beginning:	Ending:		36			
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.							37		
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			Beginning:	Ending:		38			
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)							1	2	39
								N	N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.520?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1. (see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery (see instructions)				61.06
Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1	2	3	4
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of (unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Title V and XIX Services		Y	XIX		
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90	
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91	
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92	
95	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	95	
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)?	Y		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106	
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II, Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.	N		107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	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.	Y	Y	109	
		Physical	Occupational	Speech	Respiratory
Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	N		115	
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N	116	
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		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	
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	212,418		118.01	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N	118.02	
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N	121	
Transplant Center Information					
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.		N	125	
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126	
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127	
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128	
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129	
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130	
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131	
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132	
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133	
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134	

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WORKSHEET S-2
PART I

All Providers					
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)		1	2	140
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141	Name:	Contractor's Name:	Contractor's Number:		141
142	Street:	P.O. Box:	142		
143	City:	State:	ZIP Code:	143	
144	Are provider based physicians' costs included in Worksheet A?		Y		144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.		N		145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.		N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.		N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.		N		149
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)					
Title XVIII					
	Part A	Part B	Title V	Title XIX	
		1	2	3	
155	Hospital	Y	Y	N	N
156	Subprovider - IPF	N	N		
157	Subprovider - IRF	N	N		
158	Subprovider - Other				
159	SNF	N	N		
160	HHA	N	N		
161	CMEHC		N		
161.10	CORF				
Multicampus					
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N			165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.				
	Name	County	State	ZIP Code	CBSA
	0	1	2	3	4
					FTE/Campus
					5
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act					
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.		Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)		1,809,706		168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			10/01/2013	09/30/2014
					170

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
FINANCIAL DATA AND REPORTS					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
APPROVED EDUCATIONAL ACTIVITIES					
		Y/N		Y/N	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS					
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
PART A					
PART B					
PS&R REPORT DATA					
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	10/01/2014	Y	10/01/2014
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART IIGENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN 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.	Y	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEBRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	N	33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	35
		Y/N	DATE
HOME OFFICE COSTS		1	2
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	N	36
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	37
38	IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE.	N	38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	N	39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	40
COST REPORT PREPARER INFORMATION			
41	FIRST NAME: DAVID	LAST NAME: SCHNAKE	TITLE: PARTNER
42	EMPLOYER: KERBER, ECK & BRAECKEL LLP		
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: DAVIDS@KEBCPA.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	34,320.00		918	112	1,430	1
2	HMO AND OTHER (see instructions)									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						924		1,055	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								111	6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		25	9,125	34,320.00		1,842	112	2,596	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43								13
14	TOTAL (see instructions)		25	9,125	34,320.00		1,842	112	2,596	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24 10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					2,412		5,765	26
27	TOTAL (sum of lines 14-26)		25							27
28	OBSERVATION BED DAYS							12	107	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					261	42	425	1
2	HMO AND OTHER (see instructions)								2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		145.44			261	42	425	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY								19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOMIE HEALTH AGENCY								22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC		9.56						26
27	TOTAL (sum of lines 14-26)		155.00						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

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

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)						1
2	EXCLUDED AREA SALARIES (see instructions)						2
3	SUBTOTAL SALARIES (line 1 minus line 2)						3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)						4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)						5
6	TOTAL (sum of lines 3 through 5)						6
7	TOTAL OVERHEAD COST (see instructions)						7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)		8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY		17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)		24

PART B - OTHER THAN CORE RELATED COST

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

EXHIBIT 3

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

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

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

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED 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 - FOHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

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

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

SNF SERVICES

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

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

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?	
		1	2	3	
202	STAFFING				202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING				205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)				207

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

COMPONENT CCN: 14-8504

WORKSHEET S-8

CHECK RHC FQHC
APPLICABLE BOX:

CLINIC ADDRESS AND IDENTIFICATION:

1	STREET: 900 N. WASHINGTON	1
2	CITY: DU QUOIN STATE: IL ZIP CODE: 62832 COUNTY: PERRY	2
3	FOHCs 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	
		N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
11	CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	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)?	1	2	
		N		13
14	PROVIDER NAME: _____ CCN NUMBER: _____			14

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

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.491355	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	2,192,108	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	4,698,794	6
7	MEDICAID COST (line 1 times line 6)	2,308,776	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.	116,668	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE			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)	116,668		19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY		597,582	597,582	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)		293,625	293,625	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)		293,625	293,625	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)	1,885,539	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	214,182	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	1,671,357	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	821,230	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,114,855	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	1,231,523	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 = col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 = col. 6)	
			1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS										
1	00100	CAP REL COSTS-BLDG & FIXT		717,303	717,303	-211,271	506,032	2,023	508,055	1
1.01	00101	2008 BLDG & FIXT				496,975	496,975		496,975	1.01
1.02	00102	RHC BLDG & FIXT				34,255	34,255		34,255	1.02
2	00200	CAP REL COSTS-MVBLE EQUIP		281,637	281,637	35,541	317,178	-55,537	261,641	2
2.01	00201	2008 MVBLE EQUIP				62,366	62,366		62,366	2.01
2.02	00202	RHC MVBLE EQUIP				1,695	1,695		1,695	2.02
3	00500	OTHER CAP REL COSTS		40,553	40,553	-40,553			-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		2,121,244	2,121,244		2,121,244		2,121,244	4
5	00500	ADMINISTRATIVE & GENERAL	990,224	1,259,474	2,249,698		2,249,698	-392,145	1,857,553	5
6	00600	MAINTENANCE & REPAIRS	172,522	128,170	300,692		300,692	-71	300,621	6
7	00700	OPERATION OF PLANT		228,364	228,364		228,364	-625	227,739	7
8	00800	LAUNDRY & LINEN SERVICE	14,679	45,154	59,833		59,833		59,833	8
9	00900	HOUSEKEEPING	231,476	39,458	270,934		270,934	-157	270,777	9
10	01000	DIETARY	214,531	136,217	350,748	-175,375	175,375	-529	174,844	10
11	01100	CAFETERIA				175,375	175,375	-39,636	135,739	11
13	01300	NURSING ADMINISTRATION	454,193	9,457	443,650		443,650	-1,430	442,220	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY	222,181	708,694	930,875		930,875	-60,915	869,960	15
16	01600	MEDICAL RECORDS & LIBRARY	196,422	57,246	253,668		253,668	-332	253,336	16
17	01700	SOCIAL SERVICE	56,843	2,280	59,123		59,123	-421	58,702	17
INPATIENT ROUTINE SERV COST CENTERS										
30	03000	ADULTS & PEDIATRICS	917,242	542,274	1,459,516		1,459,516	-368,268	1,091,248	30
ANCILLARY SERVICE COST CENTERS										
50	05000	OPERATING ROOM	220,110	6,966	227,076		227,076	3,518	230,594	50
53	05300	ANESTHESIOLOGY		240,000	240,000		240,000		240,000	53
54	05400	RADIOLOGY-DIAGNOSTIC	444,467	443,804	888,271		888,271	-713	887,558	54
60	06000	LABORATORY	448,161	232,189	680,350		680,350	-4	680,346	60
65	06500	RESPIRATORY THERAPY	215,213	55,191	270,404		270,404	-1,764	268,640	65
66	06600	PHYSICAL THERAPY	539,736	48,432	588,168		588,168	-1,353	586,815	66
67	06700	OCCUPATIONAL THERAPY								67
68	06800	SPEECH PATHOLOGY								68
69	06900	ELECTROCARDIOLOGY	24,481	6,750	31,231		31,231		31,231	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		571,292	571,292		571,292		571,292	71
73	07300	DRUGS CHARGED TO PATIENTS								73
73.01	07301	CARDIAC REHABILITATION	45,845	2,301	48,146		48,146	-2,007	46,139	73.01
76.97	07697	CARDIAC REHABILITATION								76.97
OUTPATIENT SERVICE COST CENTERS										
88	08800	RURAL HEALTH CLINIC	690,679	59,095	749,774		749,774	-401	749,373	88
91	09100	EMERGENCY	536,441	1,017,257	1,553,698		1,553,698	-593,472	960,226	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
OTHER REIMBURSABLE COST CENTERS										
SPECIAL PURPOSE COST CENTERS										
113	11300	INTEREST EXPENSE		620,821	620,821	-379,008	241,813	-241,813		113
118		SUBTOTALS (sum of lines 1-117)	6,615,446	9,621,623	16,237,069		16,237,069	-1,756,052	14,481,017	118
NONREIMBURSABLE COST CENTERS										
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES	461,503	237,978	699,481		699,481	-82,932	616,549	192
192.02	19202	INDEPENDENT LIVING	65,896	115,146	181,042		181,042	-30	181,012	192.02
192.03	19203	MEALS ON WHEELS								192.03
200		TOTAL (sum of lines 118-199)	7,142,845	9,974,747	17,117,592		17,117,592	-1,839,014	15,278,578	200

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	INCREASES			
				LINE #	SALARY	OTHER	
			2	4	5		
1	TO RECLASS CAFETERIA COSTS	A	CAFETERIA	11	107,266	68,109	1
500	TOTAL RECLASSIFICATIONS				107,266	68,109	500
	CODE LETTER - A						
1	TO RECLASS INTEREST EXP	C	CAP REL COSTS-MVBLE EQUIP	2		71,580	1
2			CAP REL COSTS-BLDG & FIXT	1		154,290	2
3			2008 BLDG & FIXT	1.01		140,887	3
4			2008 MVBLE EQUIP	2.01		12,251	4
500	TOTAL RECLASSIFICATIONS					379,008	500
	CODE LETTER - C						
1	TO RECLASS BOND AMORITZATION	D	2008 BLDG & FIXT	1.01		13,883	1
2			CAP REL COSTS-MVBLE EQUIP	2		1,950	2
3			2008 MVBLE EQUIP	2.01		1,207	3
500	TOTAL RECLASSIFICATIONS					17,040	500
	CODE LETTER - D						
1	TO RECLASS DEPRECIATION EXPENSE	E	2008 BLDG & FIXT	1.01		330,766	1
2			2008 MVBLE EQUIP	2.01		47,859	2
500	TOTAL RECLASSIFICATIONS					378,625	500
	CODE LETTER - E						
1	TO RECLASS DEPRECIATION EXPENSE	F	RHC BLDG & FIXT	1.02		34,255	1
2			RHC MVBLE EQUIP	2.02		1,695	2
500	TOTAL RECLASSIFICATIONS					35,950	500
	CODE LETTER - F						
	GRAND TOTAL (INCREASES)				107,266	878,732	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES							
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.		
		1	6	7	8	9	10		
1	TO RECLASS CAFETERIA COSTS	A	DIETARY	10	107,266	68,109			1
500	TOTAL RECLASSIFICATIONS				107,266	68,109			500
	CODE LETTER - A								
1	TO RECLASS INTEREST EXP	C	INTEREST EXPENSE	115		379,008	11		1
2							11		2
3							11		3
4							11		4
500	TOTAL RECLASSIFICATIONS					379,008			500
	CODE LETTER - C								
1	TO RECLASS BOND AMORITZATION	D	CAP REL COSTS-BLDG & FIXT	1		17,040	9		1
2							9		2
3							9		3
500	TOTAL RECLASSIFICATIONS					17,040			500
	CODE LETTER - D								
1	TO RECLASS DEPRECIATION EXPENSE	E	CAP REL COSTS-BLDG & FIXT	1		330,766	9		1
2			CAP REL COSTS-MVBLE EQUIP	2		47,859	9		2
500	TOTAL RECLASSIFICATIONS					378,625			500
	CODE LETTER - E								
1	TO RECLASS DEPRECIATION EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		34,255	9		1
2			CAP REL COSTS-MVBLE EQUIP	2		1,695	9		2
500	TOTAL RECLASSIFICATIONS					35,950			500
	CODE LETTER - F								
	GRAND TOTAL (DECREASES)				107,266	878,732			

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
			PURCHASES	DONATION	TOTAL			
		1	2	3	4	5	6	7
1	LAND	3,116					3,116	1
2	LAND IMPROVEMENTS	1,212,116					1,212,116	2
3	BUILDINGS AND FIXTURES	8,237,203	3,870		3,870	835,743	7,405,330	3
4	BUILDING IMPROVEMENTS							4
5	FIXED EQUIPMENT	6,214,051	332,786		332,786		6,546,837	5
6	MOVABLE EQUIPMENT	4,848,094	92,216		92,216	23,483	4,916,827	6
7	HIT DESIGNATED ASSETS	120,596	1,809,706		1,809,706		1,930,302	7
8	SUBTOTAL (sum of lines 1-7)	20,635,176	2,238,578		2,238,578	859,226	22,014,528	8
9	RECONCILING ITEMS							9
10	TOTAL (line 7 minus line 9)	20,635,176	2,238,578		2,238,578	859,226	22,014,528	10

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

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	717,303						717,303	1
1.01	2008 BLDG & FIXT								1.01
1.02	RHC BLDG & FIXT								1.02
2	CAP REL COSTS-MVBLE EQUIP	281,637						281,637	2
2.01	2008 MVBLE EQUIP								2.01
2.02	RHC MVBLE EQUIP								2.02
3	TOTAL (sum of lines 1-2)	998,940						998,940	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	8,957,790		8,957,790	0.406903			16,500	16,500	1
1.01	2008 BLDG & FIXT	6,209,605		6,209,605	0.282069			11,439	11,439	1.01
1.02	RHC BLDG & FIXT				0.000000					1.02
2	CAP REL COSTS-MVBLE EQU	6,277,933		6,277,933	0.285172			11,565	11,565	2
2.01	2008 MVBLE EQUIP	569,200		569,200	0.025856			1,049	1,049	2.01
2.02	RHC MVBLE EQUIP				0.000000					2.02
3	TOTAL (sum of lines 1-2)	22,014,528		22,014,528	1.000000			40,553	40,553	3

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	335,242		156,313			16,500	508,055	1
1.01	2008 BLDG & FIXT	344,649		140,887			11,439	496,975	1.01
1.02	RHC BLDG & FIXT	34,255						34,255	1.02
2	CAP REL COSTS-MVBLE EQUIP	180,374		69,702			11,565	261,641	2
2.01	2008 MVBLE EQUIP	49,066		12,251			1,049	62,366	2.01
2.02	RHC MVBLE EQUIP	1,695						1,695	2.02
3	TOTAL (sum of lines 1-2)	945,281		379,153			40,553	1,364,987	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-281	CAP REL COSTS-BLDG & FIXT	1	11
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)	B	-1,878	CAP REL COSTS-MVBLE EQUIP	2	11
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 5)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL.) (chapter 21)					7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-598,185			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1				12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-39,636	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-58,698	PHARMACY	15	17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-332	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 OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION-BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION-MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND	A	-53,659	CAP REL COSTS-MVBLE EQUIP	2	9
33	MISCELLANEOUS INCOME	B	-64,773	ADMINISTRATIVE & GENERAL	5	33
34						34
35	AHA DUES USED FOR LOBBYING	A	-2,094	ADMINISTRATIVE & GENERAL	5	35
36	IHA DUES USED FOR LOBBYING	A	-9,213	ADMINISTRATIVE & GENERAL	5	36
37	MARKETING	A	-58,633	ADMINISTRATIVE & GENERAL	5	37
38						38
39	DR. HALL SHARED EXPENSES	A	-80,874	PHYSICIANS' PRIVATE OFFICES	192	39
40	DEPRECIATION	A	2,304	CAP REL COSTS-BLDG & FIXT	1	11
41	DEPRECIATION	A	21,988	ADMINISTRATIVE & GENERAL	5	41
42	DEPRECIATION	A	-71	MAINTENANCE & REPAIRS	6	42
43	DEPRECIATION	A	-625	OPERATION OF PLANT	7	43
44	DEPRECIATION	A	-157	HOUSEKEEPING	9	44
45	DEPRECIATION	A	-529	DIETARY	10	45
45.01	DEPRECIATION	A	-1,430	NURSING ADMINISTRATION	13	45.01
45.02	DEPRECIATION	A	-2,217	PHARMACY	15	45.02
45.03	DEPRECIATION	A	-421	SOCIAL SERVICE	17	45.03
45.04	DEPRECIATION	A	7,391	ADULTS & PEDIATRICS	30	45.04
45.05	DEPRECIATION	A	3,518	OPERATING ROOM	50	45.05
45.06	DEPRECIATION	A	-713	RADIOLOGY-DIAGNOSTIC	54	45.06
45.07	DEPRECIATION	A	-2,007	CARDIAC REHABILITATION	73.01	45.07
45.08	DEPRECIATION	A	-4	LABORATORY	60	45.08
45.09	DEPRECIATION	A	-1,764	RESPIRATORY THERAPY	65	45.09
45.10	DEPRECIATION	A	-1,353	PHYSICAL THERAPY	66	45.10
45.11	DEPRECIATION	A	4,713	EMERGENCY	91	45.11
45.12	DEPRECIATION	A	-401	RURAL HEALTH CLINIC	88	45.12
45.13	DEPRECIATION	A	-2,058	PHYSICIANS' PRIVATE OFFICES	192	45.13
45.14	DEPRECIATION	A	-30	INDEPENDENT LIVING	192.02	45.14
45.16	SWAP UNALLOWABLE INTEREST	A	-241,813	INTEREST EXPENSE	113	45.16
45.17	HOSPITALIST PHYSICIAN FEES	A	-375,659	ADULTS & PEDIATRICS	30	45.17
46						46
47	PROVIDER TAX ASSESSMENT	A	-279,420	ADMINISTRATIVE & GENERAL	5	47

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,839,014			50

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1
- (2) Basis for adjustment (see instructions)
 - A. Costs - if cost, including applicable overhead, can be determined
 - B. Amount Received - if cost cannot be determined
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	10
1	91	EMERGENCY AGGREGATE	990,373	598,185	392,188					1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	990,373	598,185	392,188					200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	10	11	12	13	14	15	16	17	18	19	20
	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT		
1	91	EMERGENCY AGGREGATE							598,185		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
200		TOTAL							598,185		200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)								1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK								2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)							4	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)								4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)								5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)								6
7	STANDARD TRAVEL EXPENSE RATE							5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE								8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES			
		1	2	3	4	5			
9	TOTAL HOURS WORKED		6.25						9
10	AHSEA (see instructions)		70.30						10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.15	35.15						11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)								12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)								12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)								13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)								13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)								14
15	THERAPISTS (column 2, line 9 times column 2, line 10)							439	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)								16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)							439	17
18	AIDES (column 4, line 9 times column 4, line 10)								18
19	TRAINEES (column 5, line 9 times column 5, line 10)								19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)							439	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.								
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)								21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)								22
23	TOTAL SALARY EQUIVALENCY (see instructions)							439	23

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

STANDARD TRAVEL ALLOWANCE									
24	THERAPISTS (line 3 times column 2, line 11)							141	24
25	ASSISTANTS (line 4 times column 3, line 11)								25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)							141	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)							20	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)							161	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE									
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)								29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)								30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)								31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)								32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)							161	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)								34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)								35

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

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

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W I N L A S H

Micro System

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)					439	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)					161	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)					600	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)					344	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					59	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					885	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					100	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		336.75				9
10	AHSEA (see instructions)		74.18				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.09	37.09				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					24,980	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					24,980	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					24,980	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)					74.18	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)					65,649	22
23	TOTAL SALARY EQUIVALENCY (see instructions)					65,649	23

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

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)					3,709	24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,709	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					500	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)					4,209	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)					4,209	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

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

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

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	65,649	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	4,209	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)		59
60	OVERTIME ALLOWANCE (from column 5, line 56)		60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)	69,858	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	20,523	64
65	EXCESS OVER LIMITATION (line 64 minus line 63, if negative enter zero)		65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)						1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK						2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					6	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISIT(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		12.00				9
10	AHSEA (see instructions)		67.56				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	33.78	33.78				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					811	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					811	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					811	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)						22
23	TOTAL SALARY EQUIVALENCY (see instructions)					811	23

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

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)					203	24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					203	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					30	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)					233	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)					233	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

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

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

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		811	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)		235	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)			59
60	OVERTIME ALLOWANCE (from column 5, line 56)			60
61	EQUIPMENT COST (see instructions)			61
62	SUPPLIES (see instructions)			62
63	TOTAL ALLOWANCE (sum of lines 57-62)		1,044	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		540	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)			65

Optimizer Systems, Inc.

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP BLDGS + FIXTURES	CAP REL COSTS- BLDG & FIX	CAP MOVABLE EQUIPMENT	CAP MOVABLE EQUIPMENT	
		0	1	1.01	1.02	2	2.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	508,055	508,055					1
1.01	2008 BLDG & FIXT	496,975		496,975				1.01
1.02	RHC BLDG & FIXT	34,255			34,255			1.02
2	CAP REL COSTS-MVBLE EQUIP	261,641				261,641		2
2.01	2008 MVBLE EQUIP	62,366					62,366	2.01
2.02	RHC MVBLE EQUIP	1,695						2.02
4	EMPLOYEE BENEFITS DEPARTMENT	2,121,244						4
5	ADMINISTRATIVE & GENERAL	1,857,553	136,940	13,296		95,435		5
6	MAINTENANCE & REPAIRS	300,621						6
7	OPERATION OF PLANT	227,739	43,564	4,685		1,443		7
8	LAUNDRY & LINEN SERVICE	59,833	17,103			366		8
9	HOUSEKEEPING	270,777	9,755			1,368		9
10	DIETARY	174,844	20,491			365		10
11	CAFETERIA	135,739	6,087			365		11
13	NURSING ADMINISTRATION	442,220	4,968			787		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	869,960		27,281		1,537	6,794	15
16	MEDICAL RECORDS & LIBRARY	253,356	10,736			2,815		16
17	SOCIAL SERVICE	58,702	1,053					17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,091,248		279,119		12,865	49,166	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	230,594		127,103		21,832	1,590	50
53	ANESTHESIOLOGY	240,000						53
54	RADIOLOGY-DIAGNOSTIC	887,558	10,951			67,993		54
60	LABORATORY	680,346	3,076	45,491		14,027	4,816	60
65	RESPIRATORY THERAPY	268,640	16,654			12,004		65
66	PHYSICAL THERAPY	586,815	27,417			6,365		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	31,231	488					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	571,292						71
73	DRUGS CHARGED TO PATIENTS							73
73.01	CARDIAC REHABILITATION	46,139	4,312			8,224		73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	749,373			34,255			88
91	EMERGENCY	960,226	18,651			9,883		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	14,481,017	332,246	496,975	34,255	257,674	62,366	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,313					190
192	PHYSICIANS' PRIVATE OFFICES	616,549	35,064			3,231		192
192.02	INDEPENDENT LIVING	181,012	135,432			736		192.02
192.03	MEALS ON WHEELS							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	15,278,578	508,055	496,975	34,255	261,641	62,366	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAP MVBLE EQUI	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		2.02	4	4A	5	6	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	CAP REL COSTS-MVBLE EQUIP							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP	1,695						2.02
4	EMPLOYEE BENEFITS DEPARTMENT		2,121,244					4
5	ADMINISTRATIVE & GENERAL		294,070	2,397,294	2,397,294			5
6	MAINTENANCE & REPAIRS		51,235	351,856	65,485	417,339		6
7	OPERATION OF PLANT			277,431	51,632		329,063	7
8	LAUNDRY & LINEN SERVICE		4,359	81,661	15,198	3,777	17,171	8
9	HOUSEKEEPING		68,743	350,643	65,257	4,721	9,793	9
10	DIETARY		31,855	227,555	42,350	22,661	20,572	10
11	CAFETERIA		31,855	174,046	32,391		6,111	11
13	NURSING ADMINISTRATION		128,944	576,919	107,369		4,988	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		65,982	971,554	180,813	4,721	7,756	15
16	MEDICAL RECORDS & LIBRARY		58,332	325,219	60,526	14,163	10,779	16
17	SOCIAL SERVICE		16,881	76,636	14,262		1,058	17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		272,398	1,704,796	317,271	163,348	79,356	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		65,367	446,486	83,094	27,382	36,137	50
53	ANESTHESIOLOGY			240,000	44,666			53
54	RADIOLOGY-DIAGNOSTIC		131,996	1,098,498	204,438	11,330	10,994	54
60	LABORATORY		133,093	880,849	163,932	22,661	16,022	60
65	RESPIRATORY THERAPY		63,913	361,211	67,224	12,275	16,720	65
66	PHYSICAL THERAPY		160,288	780,855	145,328	9,442	27,525	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		7,270	38,989	7,256		490	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			571,292	106,321			71
73	DRUGS CHARGED TO PATIENTS							73
73.01	CARDIAC REHABILITATION		13,615	72,290	13,454	2,833	4,329	73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,695	205,114	990,437	184,327	11,330		88
91	EMERGENCY		159,310	1,148,070	213,664	36,824	18,725	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,695	1,964,620	14,144,617	2,186,256	347,468	288,526	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			5,313	989		5,334	190
192	PHYSICIANS' PRIVATE OFFICES		137,055	791,899	147,378	11,330	35,203	192
192.02	INDEPENDENT LIVING		19,569	336,749	62,671	58,541		192.02
192.03	MEALS ON WHEELS							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,695	2,121,244	15,278,578	2,397,294	417,339	329,063	202

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	CAP REL COSTS-MVBLE EQUIP							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	117,807						8
9	HOUSEKEEPING	1,749	432,163					9
10	DIETARY	1,592	37,082	351,812				10
11	CAFETERIA	1,592			214,140			11
13	NURSING ADMINISTRATION				13,915	703,191		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		5,198		6,571		1,176,613	15
16	MEDICAL RECORDS & LIBRARY		3,697		13,529			16
17	SOCIAL SERVICE				2,519			17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	63,891	242,131	332,168	44,258	406,374		30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	11,119	20,447		10,823	99,603		50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	4,304	25,415		18,167			54
60	LABORATORY	897	17,444		19,907			60
65	RESPIRATORY THERAPY	3,089	7,624		10,050			65
66	PHYSICAL THERAPY	13,316	14,556		19,520			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS						1,176,613	73
73.01	CARDIAC REHABILITATION		2,195		1,739			73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	2,152	13,285		18,554			88
91	EMERGENCY	12,106	25,530		21,453	197,214		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	117,807	414,604	332,168	200,805	703,191	1,176,613	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES		16,288		8,890			192
192.02	INDEPENDENT LIVING		1,271		4,445			192.02
192.03	MEALS ON WHEELS			19,644				192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	117,807	432,163	351,812	214,140	703,191	1,176,613	202

Optimizer Systems, Inc.

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
1.01	2008 BLDG & FIXT						1.01
1.02	RHC BLDG & FIXT						1.02
2	CAP REL COSTS-MVBLE EQUIP						2
2.01	2008 MVBLE EQUIP						2.01
2.02	RHC MVBLE EQUIP						2.02
4	EMPLOYEE BENEFITS DEPARTMENT						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
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY	427,913					16
17	SOCIAL SERVICE		94,275				17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	177,678	94,275	3,625,546		3,625,546	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	23,256		758,347		758,347	50
53	ANESTHESIOLOGY			284,666		284,666	53
54	RADIOLOGY-DIAGNOSTIC	20,651		1,393,797		1,393,797	54
60	LABORATORY	35,535		1,157,247		1,157,247	60
65	RESPIRATORY THERAPY	16,000		496,193		496,193	65
66	PHYSICAL THERAPY	14,698		1,025,270		1,025,270	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY			46,735		46,735	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			677,613		677,613	71
73	DRUGS CHARGED TO PATIENTS			1,176,613		1,176,613	73
73.01	CARDIAC REHABILITATION	186		97,026		97,026	73.01
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	34,791		1,254,876		1,254,876	88
91	EMERGENCY	70,885		1,744,471		1,744,471	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	393,680	94,275	13,738,400		13,738,400	118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			11,636		11,636	190
192	PHYSICIANS' PRIVATE OFFICES	34,233		1,045,221		1,045,221	192
192.02	INDEPENDENT LIVING			463,677		463,677	192.02
192.03	MEALS ON WHEELS			19,644		19,644	192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	427,913	94,275	15,278,578		15,278,578	202

Optimizer Systems, Inc.

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Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP BLDGS + FLXTURES	CAP REL COSTS- BLDG & FIX	CAP MOVABLE EQUIPMENT	CAP MOVABLE EQUIPMENT	
		0	1	1.01	1.02	2	2.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	CAP REL COSTS-MVBLE EQUIP							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL		136,940	13,296		95,435		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		43,564	4,685		1,443		7
8	LAUNDRY & LINEN SERVICE		17,103			366		8
9	HOUSEKEEPING		9,755			1,368		9
10	DIETARY		20,491			365		10
11	CAFETERIA		6,087			365		11
13	NURSING ADMINISTRATION		4,968			787		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY			27,281		1,537	6,794	15
16	MEDICAL RECORDS & LIBRARY		10,736			2,815		16
17	SOCIAL SERVICE		1,053					17
	INFILIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS			279,119		12,865	49,166	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM			127,103		21,832	1,590	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC		10,951			67,993		54
60	LABORATORY		3,076	45,491		14,027	4,816	60
65	RESPIRATORY THERAPY		16,654			12,004		65
66	PHYSICAL THERAPY		27,417			6,365		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		488					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
73.01	CARDIAC REHABILITATION		4,312			8,224		73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC				34,255			88
91	EMERGENCY		18,651			9,883		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		332,246	496,975	34,255	257,674	62,366	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEN		5,313					190
192	PHYSICIANS' PRIVATE OFFICES		35,064			3,231		192
192.02	INDEPENDENT LIVING		135,432			736		192.02
192.03	MEALS ON WHEELS							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		508,055	496,975	34,255	261,641	62,366	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAP MVBLE EQUI	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		2.02	2A	5	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	CAP REL COSTS-MVBLE EQUIP							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL		245,671	245,671				5
6	MAINTENANCE & REPAIRS			6,711	6,711			6
7	OPERATION OF PLANT		49,692	5,291		54,983		7
8	LAUNDRY & LINEN SERVICE		17,469	1,557	61	2,869	21,956	8
9	HOUSEKEEPING		11,123	6,687	76	1,636	326	9
10	DIETARY		20,856	4,340	364	3,437	297	10
11	CAFETERIA		6,452	3,319		1,021	297	11
13	NURSING ADMINISTRATION		5,755	11,003		835		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		35,612	18,529	76	1,296		15
16	MEDICAL RECORDS & LIBRARY		13,551	6,203	228	1,801		16
17	SOCIAL SERVICE		1,053	1,462		177		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		341,150	32,513	2,628	13,261	11,908	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		150,525	8,515	440	6,038	2,072	50
53	ANESTHESIOLOGY			4,577				53
54	RADIOLOGY-DIAGNOSTIC		78,944	20,951	182	1,837	802	54
60	LABORATORY		67,410	16,800	364	2,677	167	60
65	RESPIRATORY THERAPY		28,658	6,889	197	2,794	948	65
66	PHYSICAL THERAPY		33,782	14,893	152	4,599	2,482	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		488	744		82		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			10,896				71
73	DRUGS CHARGED TO PATIENTS							73
73.01	CARDIAC REHABILITATION		12,536	1,379	46	725		73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,695	35,950	18,890	182		401	88
91	EMERGENCY		28,534	21,896	592	3,129	2,256	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,695	1,185,211	224,045	5,588	48,210	21,956	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,313	101		891		190
192	PHYSICIANS' PRIVATE OFFICES		38,295	15,103	182	5,882		192
192.02	INDEPENDENT LIVING		136,168	6,422	941			192.02
192.03	MEALS ON WHEELS							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,695	1,364,987	245,671	6,711	54,983	21,956	202

Optimizer Systems, Inc.

WinLASH

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	CAP REL COSTS-MVBLE EQUIP							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	19,848						9
10	DIETARY	1,703	30,997					10
11	CAFETERIA			11,089				11
13	NURSING ADMINISTRATION			721	18,312			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	239		340		56,092		15
16	MEDICAL RECORDS & LIBRARY	170		701			22,654	16
17	SOCIAL SERVICE			120				17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	11,121	29,266	2,292	10,582		9,407	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	939		560	2,594		1,231	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	1,167		941			1,093	54
60	LABORATORY	801		1,031			1,881	60
65	RESPIRATORY THERAPY	350		520			847	65
66	PHYSICAL THERAPY	668		1,011			778	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS					56,092		73
73.01	CARDIAC REHABILITATION	101		90			10	73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	610		961			1,842	88
91	EMERGENCY	1,173		1,111	5,136		3,753	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	19,042	29,266	10,399	18,312	56,092	20,842	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES	748		460			1,812	192
192.02	INDEPENDENT LIVING	58		230				192.02
192.03	MEALS ON WHEELS		1,731					192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	19,848	30,997	11,089	18,312	56,092	22,654	202

Optimizer Systems, Inc.

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Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
1.01	2008 BLDG & FIXT						1.01
1.02	RHC BLDG & FIXT						1.02
2	CAP REL COSTS-MVBLE EQUIP						2
2.01	2008 MVBLE EQUIP						2.01
2.02	RHC MVBLE EQUIP						2.02
4	EMPLOYEE BENEFITS DEPARTMENT						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
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE	2,812					17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,812	466,940		466,940		30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		172,914		172,914		50
53	ANESTHESIOLOGY		4,577		4,577		53
54	RADIOLOGY-DIAGNOSTIC		105,917		105,917		54
60	LABORATORY		91,131		91,131		60
65	RESPIRATORY THERAPY		41,203		41,203		65
66	PHYSICAL THERAPY		58,365		58,365		66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY		1,314		1,314		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		10,896		10,896		71
73	DRUGS CHARGED TO PATIENTS		56,092		56,092		73
73.01	CARDIAC REHABILITATION		14,885		14,885		73.01
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC		58,836		58,836		88
91	EMERGENCY		67,580		67,580		91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	2,812	1,150,650		1,150,650		118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,305		6,305		190
192	PHYSICIANS' PRIVATE OFFICES		62,482		62,482		192
192.02	INDEPENDENT LIVING		143,819		143,819		192.02
192.03	MEALS ON WHEELS		1,731		1,731		192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	2,812	1,364,987		1,364,987		202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP BLDGS + FIXTURES SQUARE FEET	CAP REL COSTS-BLDG & FIX SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	CAP MOVABLE EQUIPMENT DOLLAR VALUE	CAP MVBLE EQUIP DOLLAR VALUE	
		1	1.01	1.02	2	2.01	2.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	78,126						1
1.01	2008 BLDG & FIXT		21,642					1.01
1.02	RHC BLDG & FIXT			4,575				1.02
2	CAP REL COSTS-MVBLE EQUIP				238,144			2
2.01	2008 MVBLE EQUIP					21,341		2.01
2.02	RHC MVBLE EQUIP						1,734	2.02
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL	21,058	579		86,867			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	6,699	204		1,313			7
8	LAUNDRY & LINEN SERVICE	2,630			333			8
9	HOUSEKEEPING	1,500			1,245			9
10	DIETARY	3,151			332			10
11	CAFETERIA	936			332			11
13	NURSING ADMINISTRATION	764			716			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		1,188		1,399	2,525		15
16	MEDICAL RECORDS & LIBRARY	1,651			2,562			16
17	SOCIAL SERVICE	162						17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		12,155		11,710	16,824		30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		5,555		19,871	544		50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	1,684			61,887			54
60	LABORATORY	473	1,981		12,767	1,648		60
65	RESPIRATORY THERAPY	2,561			10,926			65
66	PHYSICAL THERAPY	4,216			5,793			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	75						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
73.01	CARDIAC REHABILITATION	663			7,485			73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC			4,575			1,734	88
91	EMERGENCY	2,868			8,995			91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	51,091	21,642	4,575	234,533	21,341	1,734	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	817						190
192	PHYSICIANS' PRIVATE OFFICES	5,392			2,941			192
192.02	INDEPENDENT LIVING	20,826			670			192.02
192.03	MEALS ON WHEELS							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	508,055	496,975	34,255	261,641	62,366	1,695	202
203	UNIT COST MULTI-WS B PT I	6.503021	22.963451	7.487432	1.098667	2.922356	0.977509	203
204	COST TO BE ALLOC PER B PT II							204
205	UNIT COST MULTI-WS B PT II							205

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS TIME SPENT	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		4	5A	5	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	CAP REL COSTS-MVBLE EQUIP							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	EMPLOYEE BENEFITS DEPARTMENT	7,142,845						4
5	ADMINISTRATIVE & GENERAL	990,224	-2,397,294	12,881,284				5
6	MAINTENANCE & REPAIRS	172,522		351,856	442			6
7	OPERATION OF PLANT			277,431		50,402		7
8	LAUNDRY & LINEN SERVICE	14,679		81,661	4	2,630	5,255	8
9	HOUSEKEEPING	231,476		350,643	5	1,500	78	9
10	DIETARY	107,265		227,555	24	3,151	71	10
11	CAFETERIA	107,266		174,046		936	71	11
13	NURSING ADMINISTRATION	434,193		376,919		764		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	222,181		971,554	5	1,188		15
16	MEDICAL RECORDS & LIBRARY	196,422		325,219	15	1,651		16
17	SOCIAL SERVICE	56,843		76,636		162		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	917,242		1,704,796	173	12,155	2,850	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	220,110		446,486	29	5,535	496	50
53	ANESTHESIOLOGY			240,000				53
54	RADIOLOGY-DIAGNOSTIC	444,467		1,098,498	12	1,684	192	54
60	LABORATORY	448,161		880,849	24	2,454	40	60
65	RESPIRATORY THERAPY	215,213		361,211	13	2,561	227	65
66	PHYSICAL THERAPY	539,736		780,885	10	4,216	594	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	24,481		38,989		75		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			571,292				71
73	DRUGS CHARGED TO PATIENTS							73
73.01	CARDIAC REHABILITATION	45,845		72,290	3	663		73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	690,679		990,437	12		96	88
91	EMERGENCY	536,441		1,148,070	39	2,868	340	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	6,615,446	-2,397,294	11,747,323	368	44,193	5,255	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEN			5,313		817		190
192	PHYSICIANS' PRIVATE OFFICES	461,503		791,899	12	5,392		192
192.02	INDEPENDENT LIVING	65,896		336,749	62			192.02
192.03	MEALS ON WHEELS							192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,121,244		2,397,294	417,339	329,063	117,807	202
203	UNIT COST MULT-WS B PT I	0.296975		0.186107	944,205882	6,528769	22,418078	203
204	COST TO BE ALLOC PER B PT II			245,671	6,711	54,983	21,956	204
205	UNIT COST MULT-WS B PT II			0.019072	15.183258	1,090889	4.178116	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION HOURS SUPPLEMENTED	PHARMACY	MEDICAL RECORDS & LIBRARY	
		TIME SPENT	MEALS SERVED	MEALS SERVED		COSTED REQUIS.	TIME SPENT	
		9	10	11	13	15	16	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	CAP REL COSTS-MVBLE EQUIP							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING	3,741						9
10	DIETARY	321	12,644					10
11	CAFETERIA			1,108				11
13	NURSING ADMINISTRATION			72	82,291			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	45		34		1,000		15
16	MEDICAL RECORDS & LIBRARY	32		70			2,300	16
17	SOCIAL SERVICE			12				17
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	2,096	11,958	229	47,556		955	30
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	177		56	11,656		125	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	220		94			111	54
60	LABORATORY	151		103			191	60
65	RESPIRATORY THERAPY	66		52			86	65
66	PHYSICAL THERAPY	126		101			79	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS					1,000		73
73.01	CARDIAC REHABILITATION	19		9			1	73.01
76.97	CARDIAC REHABILITATION							76.97
OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	115		96			157	88
91	EMERGENCY	221		111	23,079		381	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	3,589	11,938	1,039	82,291	1,000	2,116	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES	141		46			184	192
192.02	INDEPENDENT LIVING	11		23				192.02
192.03	MEALS ON WHEELS		706					192.03
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	432,163	351,812	214,140	703,191	1,176,613	427,913	202
203	UNIT COST MULT-WS B PT I	115,520716	27,824423	193,267148	8,545175	1,176,613000	186,049130	203
204	COST TO BE ALLOC PER B PT II	19,848	30,997	11,089	18,312	56,092	22,654	204
205	UNIT COST MULT-WS B PT II	5,305533	2,451519	10,008123	0,222527	56,092000	9,849565	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	SOCIAL SERVICE	TIME SPENT	17
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GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT				1
1.01	2008 BLDG & FIXT				1.01
1.02	RHC BLDG & FIXT				1.02
2	CAP REL COSTS-MVBLE EQUIP				2
2.01	2008 MVBLE EQUIP				2.01
2.02	RHC MVBLE EQUIP				2.02
4	EMPLOYEE BENEFITS DEPARTMENT				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
13	NURSING ADMINISTRATION				13
14	CENTRAL SERVICES & SUPPLY				14
15	PHARMACY				15
16	MEDICAL RECORDS & LIBRARY				16
17	SOCIAL SERVICE	456			17
INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	456			30
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM				50
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC				54
60	LABORATORY				60
65	RESPIRATORY THERAPY				65
66	PHYSICAL THERAPY				66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				71
73	DRUGS CHARGED TO PATIENTS				73
73.01	CARDIAC REHABILITATION				73.01
76.97	CARDIAC REHABILITATION				76.97
OUTPATIENT SERVICE COST CENTERS					
88	RURAL HEALTH CLINIC				88
91	EMERGENCY				91
92	OBSERVATION BEDS (NON-DISTINCT PART)				92
OTHER REIMBURSABLE COST CENTERS					
SPECIAL PURPOSE COST CENTERS					
118	SUBTOTALS (sum of lines 1-117)	456			118
NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192	PHYSICIANS' PRIVATE OFFICES				192
192.02	INDEPENDENT LIVING				192.02
192.03	MEALS ON WHEELS				192.03
200	CROSS FOOT ADJUSTMENTS				200
201	NEGATIVE COST CENTER				201
202	COST TO BE ALLOC PER B PT I	94,275			202
203	UNIT COST MULTI-WS B PT I	206,743,421			203
204	COST TO BE ALLOC PER B PT II	2,812			204
205	UNIT COST MULTI-WS B PT II	6,166,667			205

Optimizer Systems, Inc.

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Micro System

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		PART	LINE NO.		
	1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART 1

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,625,546		3,625,546		3,625,546	30
	ANCILLARY SERVICE COST CENTERS						
30	OPERATING ROOM	758,347		758,347		758,347	50
53	ANESTHESIOLOGY	284,666		284,666		284,666	53
54	RADIOLOGY-DIAGNOSTIC	1,393,797		1,393,797		1,393,797	54
60	LABORATORY	1,157,247		1,157,247		1,157,247	60
65	RESPIRATORY THERAPY	496,193		496,193		496,193	65
66	PHYSICAL THERAPY	1,025,270		1,025,270		1,025,270	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	46,735		46,735		46,735	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	677,613		677,613		677,613	71
73	DRUGS CHARGED TO PATIENTS	1,176,613		1,176,613		1,176,613	73
73.01	CARDIAC REHABILITATION	97,026		97,026		97,026	73.01
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	1,254,876		1,254,876		1,254,876	88
91	EMERGENCY	1,744,471		1,744,471		1,744,471	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	149,073		149,073		149,073	92
	OTHER REIMBURSABLE COST CENTERS						
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	13,887,473		13,887,473		13,887,473	200
201	LESS OBSERVATION BEDS	149,073		149,073		149,073	201
202	TOTAL (SEE INSTRUCTIONS)	13,738,400		13,738,400		13,738,400	202

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,013,881		1,013,881				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	328,039	539,202	867,241	0.874436	0.874436	0.874436	50
53	ANESTHESIOLOGY	65,790	286,722	352,512	0.807536	0.807536	0.807536	53
54	RADIOLOGY-DIAGNOSTIC	837,562	6,571,566	7,409,128	0.188119	0.188119	0.188119	54
60	LABORATORY	1,410,614	5,569,737	6,980,351	0.165786	0.165786	0.165786	60
65	RESPIRATORY THERAPY	563,369	554,979	1,118,348	0.443684	0.443684	0.443684	65
66	PHYSICAL THERAPY	394,365	1,870,612	2,264,977	0.452662	0.452662	0.452662	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	238,000	461,880	699,880	0.066776	0.066776	0.066776	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	842,208	875,672	1,717,880	0.394447	0.394447	0.394447	71
73	DRUGS CHARGED TO PATIENTS	886,752	985,706	1,872,458	0.628379	0.628379	0.628379	73
73.01	CARDIAC REHABILITATION		173,529	173,529	0.559134	0.559134	0.559134	73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		609,286	609,286				88
91	EMERGENCY	74,424	1,978,924	2,053,348	0.849574	0.849574	0.849574	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	51,643	775,746	827,389	0.180173	0.180173	0.180173	92
	OTHER REIMBURSABLE COST CENTERS							
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	6,706,647	21,253,561	27,960,208				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	6,706,647	21,253,561	27,960,208				202

Optimizer Systems, Inc.

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1331

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.874436		229,153			200,380		50
53	ANESTHESIOLOGY	0.807536		112,302			90,688		53
54	RADIOLOGY-DIAGNOSTIC	0.188119		2,684,950			505,090		54
60	LABORATORY	0.165786		2,538,830			420,902		60
65	RESPIRATORY THERAPY	0.443684		162,095			71,919		65
66	PHYSICAL THERAPY	0.452662		623,132			282,068		66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.066776		131,031			8,750		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.394447		646,129			254,864		71
73	DRUGS CHARGED TO PATIENTS	0.628379		728,469			457,755		73
73.01	CARDIAC REHABILITATION	0.559134		69,241			38,715		73.01
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
91	EMERGENCY	0.849574		648,643			551,070		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.180173		389,373			70,155		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)			8,963,348			2,952,356		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			8,963,348			2,952,356		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z331

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.874436						50
53	ANESTHESIOLOGY	0.807536						53
54	RADIOLOGY-DIAGNOSTIC	0.183119						54
60	LABORATORY	0.165786						60
65	RESPIRATORY THERAPY	0.445684						65
66	PHYSICAL THERAPY	0.452662						66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	0.066776						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.394447						71
73	DRUGS CHARGED TO PATIENTS	0.628379						73
73.01	CARDIAC REHABILITATION	0.559134						73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
91	EMERGENCY	0.849574						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.180173						92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK [] TITLE V [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] TEFRA
 BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 + col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	466,940	191,149	275,791	1,537	179.43	112	20,096	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY								43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	466,940		275,791	1,537		112	20,096	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period: From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1331

WORKSHEET D
PART II

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 + col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	172,914	867,241	0.199384	24,294	4,844	50
53	ANESTHESIOLOGY	4,577	352,512	0.012984	8,262	107	53
54	RADIOLOGY-DIAGNOSTIC	105,917	7,409,128	0.014295	124,183	1,775	54
60	LABORATORY	91,131	6,980,351	0.013055	122,417	1,598	60
65	RESPIRATORY THERAPY	41,203	1,118,348	0.036843	28,130	1,036	65
66	PHYSICAL THERAPY	58,365	2,264,977	0.025768	2,039	53	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	1,314	699,880	0.001877	7,101	13	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,896	1,717,880	0.006343	95,565	606	71
73	DRUGS CHARGED TO PATIENTS	56,092	1,872,458	0.029956	49,338	1,478	73
73.01	CARDIAC REHABILITATION	14,885	173,529	0.085778			73.01
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	58,836	609,286	0.096565			88
91	EMERGENCY	67,580	2,053,348	0.032912	25,797	849	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	32,506	827,389	0.039287			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	716,216	26,946,327		487,126	12,359	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win L A S H

Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5+ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)
6		7		8	9
	INPATIENT ROUTINE SERV COST CENTERS				
30	ADULTS & PEDIATRICS (General Routine Care)	1,537		112	30
31	INTENSIVE CARE UNIT				31
32	CORONARY CARE UNIT				32
33	BURN INTENSIVE CARE UNIT				33
34	SURGICAL INTENSIVE CARE UNIT				34
35	OTHER SPECIAL CARE (SPECIFY)				35
40	SUBPROVIDER - IPF				40
41	SUBPROVIDER - IRF				41
42	SUBPROVIDER I				42
43	NURSERY				43
44	SKILLED NURSING FACILITY				44
45	NURSING FACILITY				45
200	TOTAL (lines 30-199)	1,537		112	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1331

WORKSHEET D
PART IV

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

		NON PHYSICIAN ANESTH- ETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPAT- IENT COST (sum of col. 2, 3, and 4)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
73	DRUGS CHARGED TO PATIENTS							73
73.01	CARDIAC REHABILITATION							73.01
76.97	CARDIAC REHABILITATION							76.97
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1331

WORKSHEET D
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
7	8	9	10	11	12	15		
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	867,241			24,294			50
53	ANESTHESIOLOGY	352,512			8,262			53
54	RADIOLOGY-DIAGNOSTIC	7,409,128			124,183			54
60	LABORATORY	6,980,351			122,417			60
65	RESPIRATORY THERAPY	1,118,348			28,130			65
66	PHYSICAL THERAPY	2,264,977			2,039			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	699,880			7,101			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,717,880			95,565			71
73	DRUGS CHARGED TO PATIENTS	1,872,458			49,338			73
73.01	CARDIAC REHABILITATION	173,529						73.01
76.97	CARDIAC REHABILITATION							76.97
OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	609,286						88
91	EMERGENCY	2,055,348			25,797			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	827,389						92
OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	26,946,327			487,126			200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1331

WORKSHEET D
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.874436							50
53	ANESTHESIOLOGY	0.807536							53
54	RADIOLOGY-DIAGNOSTIC	0.188119							54
60	LABORATORY	0.165786							60
65	RESPIRATORY THERAPY	0.443684							65
66	PHYSICAL THERAPY	0.452662							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.066776							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.394447							71
73	DRUGS CHARGED TO PATIENTS	0.628379							73
73.01	CARDIAC REHABILITATION	0.559134							73.01
76.97	CARDIAC REHABILITATION								76.97
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
91	EMERGENCY	0.849574							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.180173							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,393.22	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,278,976	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)					1,278,976	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 + col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					773,386	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					2,052,362	49

PASS-THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					643,668	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					643,668	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)					1,287,336	66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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Micro System

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					107	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,393.21	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					149,073	89
		COST	ROUTINE COST (from line 27)	column 1 + column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	466,940	2,141,370	0,218,057	149,073	32,506	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PART 1

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	2,703	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	1,537	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	1,430	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	528	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)	527	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	56	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)	55	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	112	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	127.60	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	130.60	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	3,625,546	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)	7,146	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	7,183	25
26	TOTAL SWING-BED COST (see instructions)	1,484,176	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,141,370	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 + line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 + line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 + line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,141,370	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,393.22	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	156,041	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)	156,041	41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
	1	2	3	4	5	
42	NURSERY (Titles V and XIX only)					42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					43
44	CORONARY CARE UNIT					44
45	BURN INTENSIVE CARE UNIT					45
46	SURGICAL INTENSIVE CARE UNIT					46
47	OTHER SPECIAL CARE (SPECIFY)					47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	176,064	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	332,105	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	20,096	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	12,359	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	32,455	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	299,650	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					107	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 * line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 + column 2	TOTAL OBSERVATION BED COST (from line 89)		OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1331

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		655,695		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.874436	37,534	32,821	50
53	ANESTHESIOLOGY	0.807536	25,398	20,510	53
54	RADIOLOGY-DIAGNOSTIC	0.188119	393,300	74,025	54
60	LABORATORY	0.165786	637,125	105,626	60
65	RESPIRATORY THERAPY	0.443684	239,420	106,227	65
66	PHYSICAL THERAPY	0.452662	71,222	32,239	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.066776	138,192	9,228	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.394447	431,679	170,274	71
73	DRUGS CHARGED TO PATIENTS	0.628379	318,315	200,022	73
73.01	CARDIAC REHABILITATION	0.559134			73.01
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
91	EMERGENCY	0.849574	26,383	22,414	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.180173			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		2,318,768	773,386	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		2,318,768		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1531	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z331

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.874436			50
53	ANESTHESIOLOGY	0.807536			53
54	RADIOLOGY-DIAGNOSTIC	0.188119	58,707	11,044	54
60	LABORATORY	0.165786	294,195	48,773	60
65	RESPIRATORY THERAPY	0.443684	138,528	61,463	65
66	PHYSICAL THERAPY	0.452662	232,596	105,287	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.066776	15,936	1,064	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.394447	199,049	78,514	71
73	DRUGS CHARGED TO PATIENTS	0.628379	318,295	200,010	73
73.01	CARDIAC REHABILITATION	0.559134			73.01
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
91	EMERGENCY	0.849574			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.180173			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,257,306	506,155	200
201	LESS PBP CLINIC LABORATORY SERVICES PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,257,306		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1331

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		103,218		30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.874436	24,294	21,244	50
53	ANESTHESIOLOGY	0.807536	8,262	6,672	53
54	RADIOLOGY-DIAGNOSTIC	0.188119	124,183	23,361	54
60	LABORATORY	0.165786	122,417	20,295	60
65	RESPIRATORY THERAPY	0.443684	28,130	12,481	65
66	PHYSICAL THERAPY	0.452662	2,039	923	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.066776	7,101	474	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.394447	95,565	37,695	71
73	DRUGS CHARGED TO PATIENTS	0.628379	49,338	31,003	73
75.01	CARDIAC REHABILITATION	0.559134			73.01
76.97	CARDIAC REHABILITATION				76.97
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
91	EMERGENCY	0.849574	25,797	21,916	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.180173			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		487,126	176,064	200
201	LESS BPB CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		487,126		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1331

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	2,952,356			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	2,952,356			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)				17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	2,981,880			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	36,518			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,299,044			26
27	SUBTOTAL (lines 21 and 24 - the sum of lines 25 and 26 plus the sum of lines 22 and 23) (see instructions)	1,646,318			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst F-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	1,646,318			30
31	PRIMARY PAYER PAYMENTS	182			31
32	SUBTOTAL (line 30 minus line 31)	1,646,136			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	212,984			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	187,426			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	212,984			36
37	SUBTOTAL (see instructions)	1,833,562			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	1,833,562			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	36,671			40.01
41	INTERIM PAYMENTS	1,702,616			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	94,275			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	53,449			44

TO BE COMPLETED BY CONTRACTOR

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1331

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,530,746		1,702,616	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	01	02/12/2014			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	02	04/30/2014		159,000	3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO				3.04
		PROVIDER				3.05
		06				3.06
		07				3.07
		08				3.08
		09				3.09
		10				3.10
		50				3.50
		51				3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
		55				3.55
		56				3.56
		57				3.57
		58				3.58
		59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	99	160,731			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,691,477		1,702,616	4
	TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	01				5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	02				5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
		06				5.06
		07				5.07
		08				5.08
		09				5.09
		10				5.10
		50				5.50
		51				5.51
		PROVIDER				5.52
		TO				5.53
		PROGRAM				5.54
		55				5.55
		56				5.56
		57				5.57
		58				5.58
		59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)	01	176,621		130,946	6.01
	BASED ON THE COST REPORT (1)	02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		1,868,098		1,833,562	7
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

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

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MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z331

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,562,355			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.01	02/12/2014	1,480		3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.02	04/30/2014	34,200		3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM .03				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO (1)	TO .04				3.04
		PROVIDER .05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
		PROVIDER .52				3.52
		TO .53				3.53
		PROGRAM .54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		35,680		3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			1,598,035		4
TO BE COMPLETED BY CONTRACTOR						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	.01				5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	.02				5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM .03				5.03
		TO .04				5.04
		PROVIDER .05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		PROVIDER .52				5.52
		TO .53				5.53
		PROGRAM .54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)	.01		198,319		6.01
	BASED ON THE COST REPORT (1)	.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			1,796,354		7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART IICHECK HOSPITAL CAH
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	425	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	918	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	1,430	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 209	27,960,208	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	597,582	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	1,809,706	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	1,549,470	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	30,989	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1,518,481	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1,518,481	32

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z331

WORKSHEET E-2

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B
		1	2
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	1,500,209	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)	511,217	3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)		4
5	PROGRAM DAYS	924	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)	1,811,426	8
9	PRIMARY PAYER PAYMENTS (see instructions)	9,800	9
10	SUBTOTAL (line 8 minus line 9)	1,801,626	10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)		11
12	SUBTOTAL (line 10 minus line 11)	1,801,626	12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	5,272	13
14	80% OF PART B COSTS (line 12 x 80%)		14
15	SUBTOTAL (enter the lesser of line 12 minus line 13, or line 14)	1,796,354	15
16	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		16
17	ALLOWABLE BAD DEBTS (see instructions)		17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		18
19	TOTAL (see instructions)	1,796,354	19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	35,927	19.01
20	INTERIM PAYMENTS	1,598,035	20
21	TENTATIVE SETTLEMENT (for contractor use only)		21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	162,392	22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	32,558	23

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MARSHALL BROWNING HOSPITAL Provider CCN: 14-1531	In Lieu of Form CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

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

1	INPATIENT SERVICES	2,052,362	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	2,052,362	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	2,072,886	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (not to exceed 1.000000)	0.000000	13
14	TOTAL CUSTOMARY CHARGES (see instructions)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 14 exceeds line 6) (see instructions)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 6 exceeds line 14) (see instructions)		16
17	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	2,072,886	19
20	DEDUCTIBLES (exclude professional component)	231,544	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	1,841,342	22
23	COINSURANCE		23
24	SUBTOTAL (line 22 minus line 23)	1,841,342	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	30,404	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	26,756	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	30,404	27
28	SUBTOTAL (sum of lines 24 and 26)	1,868,098	28
29	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		29
30	SUBTOTAL (line 28 plus or minus line 29)	1,868,098	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	37,362	30.01
31	INTERIM PAYMENTS	1,691,477	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	139,259	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2	37,345	34

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1331

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX
	COMPUTATION OF NET COST OF COVERED SERVICES		
1	INPATIENT HOSPITAL SNF/NF SERVICES		1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (certified transplant centers only)		3
4	SUBTOTAL (sum of lines 1, 2 and 3)		4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)		7
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
8	ROUTINE SERVICE CHARGES		8
9	ANCILLARY SERVICE CHARGES	487,126	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)		12
	CUSTOMARY CHARGES		
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)		15
16	TOTAL CUSTOMARY CHARGES (see instructions)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)		18
19	INTERNS AND RESIDENTS (see instructions)		19
20	COST OF TEACHING PHYSICIANS (see instructions)		20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)		21
	PROSPECTIVE PAYMENT AMOUNT		
22	OTHER THAN OUTLIER PAYMENTS		22
23	OUTLIER PAYMENTS		23
24	PROGRAM CAPITAL PAYMENTS		24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)		25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27	SUBTOTAL (sum of lines 22 through 26)		27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)		28
29	SUM OF LINES 27 AND 21		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
30	EXCESS OF REASONABLE COST (from line 18)		30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)		31
32	DEDUCTIBLES		32
33	COINSURANCE		33
34	ALLOWABLE BAD DEBTS (see instructions)		34
35	UTILIZATION REVIEW		35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	SUBTOTAL (line 36 ± line 37)		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)		40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

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BALANCE SHEET

WORKSHEET G

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

ASSETS (Omit Cents)		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	246,894				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	3,708,167				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-400,000				6
7	INVENTORY	484,173				7
8	PREPAID EXPENSES	518,393				8
9	OTHER CURRENT ASSETS	400,000				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	4,757,627				11
FIXED ASSETS						
12	LAND	3,114				12
13	LAND IMPROVEMENTS	1,212,116				13
14	ACCUMULATED DEPRECIATION	-726,001				14
15	BUILDINGS	7,405,330				15
16	ACCUMULATED DEPRECIATION	-3,024,256				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	6,546,837				19
20	ACCUMULATED DEPRECIATION	-3,619,389				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	6,843,374				23
24	ACCUMULATED DEPRECIATION	-4,125,489				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS	120,596				27
28	ACCUMULATED DEPRECIATION	-20,417				28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	10,615,815				30
OTHER ASSETS						
31	INVESTMENTS	7,660,893				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	344,611				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	8,005,504				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	23,378,946				36
LIABILITIES AND FUND BALANCES (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	307,692				37
38	SALARIES, WAGES & FEES PAYABLE	959,354				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	680,994				40
41	DEFERRED INCOME	34,107				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	75,502				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	2,057,649				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	9,870,291				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	1,716,785				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	11,587,076				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	13,644,725				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	9,734,221				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	9,734,221				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	23,378,946				60

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		9,289,810			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		444,411			2
3	TOTAL (sum of line 1 and line 2)		9,734,221			3
4	ADDITIONS (credit adjustments)					4
5	RESTRICTED CONTRIBUTIONS					5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		9,734,221			11
12	DEDUCTIONS (debit adjustments)					12
13	RELEASED FROM RESTRICTION					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		9,734,221			19

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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	1,013,881		1,013,881	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	417,593		417,593	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	1,431,474		1,431,474	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				15
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	1,431,474		1,431,474	17
18	ANCILLARY SERVICES	8,071,288	13,873,729	21,945,017	18
19	OUTPATIENT SERVICES		7,904,629	7,904,629	19
20	RHC		609,286	609,286	20
21	FOHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	9,502,762	22,387,644	31,890,406	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 5, line 200)		17,117,592	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		17,117,592	43

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	31,890,406	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	16,143,108	2
3	NET PATIENT REVENUES (line 1 minus line 2)	15,747,298	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	17,117,592	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-1,370,294	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	45,807	6
7	INCOME FROM INVESTMENTS		7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	39,636	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS	274,756	15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	58,698	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	332	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (GAIN ON INVESTMENTS - NET)		24
24.01	OTHER (OTHER INCOME)	1,344,543	24.01
24.02	OTHER (OTHER GAINS)	50,953	24.02
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,814,705	25
26	TOTAL (line 5 plus line 25)	444,411	26
27.01	OTHER EXPENSES (LOSS ON SWAP HEDGING)		27.01
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	444,411	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-1331

WORKSHEET L

CHECK TITLE V HOSPITAL PPS
 APPLICABLE TITLE XVIII, PART A SUB (OTHER) COST METHOD
 BOXES: TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS 0	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25	TOTAL 26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
1.01	2008 BLDG & FIXT						1.01
1.02	RHC BLDG & FIXT						1.02
2	CAP REL COSTS-MVBLE EQUIP						2
2.01	2008 MVBLE EQUIP						2.01
2.02	RHC MVBLE EQUIP						2.02
4	EMPLOYEE BENEFITS DEPARTMENT						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
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
60	LABORATORY						60
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
73	DRUGS CHARGED TO PATIENTS						73
73.01	CARDIAC REHABILITATION						73.01
76.97	CARDIAC REHABILITATION						76.97
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC						88
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
192.02	INDEPENDENT LIVING						192.02
192.03	MEALS ON WHEELS						192.03
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202

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

COMPONENT CCN: 14-8504

WORKSHEET M-1

CHECK APPLICABLE BOX: RHC I FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 5 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	418,519		418,519		418,519		418,519	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	54,542		54,542		54,542		54,542	3
4 VISITING NURSE								4
5 OTHER NURSE	64,367		64,367		64,367		64,367	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (sum of lines 1-9)	537,428		537,428		537,428		537,428	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (sum of lines 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		9,035	9,035		9,035		9,035	15
16 TRANSPORTATION (Health Care Staff)		7,107	7,107		7,107		7,107	16
17 DEPRECIATION-MEDICAL EQUIPMENT						-401	-401	17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (sum of lines 15-20)		16,142	16,142		16,142	-401	15,741	21
22 TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	537,428	16,142	553,570		553,570	-401	553,169	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS		5,017	5,017		5,017		5,017	29
30 ADMINISTRATIVE COSTS	153,251	37,936	191,187		191,187		191,187	30
31 TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	153,251	42,953	196,204		196,204		196,204	31
32 TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	690,679	59,095	749,774		749,774	-401	749,373	32

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

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-8504

WORKSHEET M-2

CHECK APPLICABLE BOX: RHC I FQHC

VISITS AND PRODUCTIVITY

	POSITIONS	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
		1	2	3	4	5	
1	PHYSICIANS	1.57	4,384	4,200	6,594		1
2	PHYSICIAN ASSISTANTS		1,581	2,100			2
3	NURSE PRACTITIONERS	0.54		2,100	1,154		3
4	SUBTOTAL (sum of lines 1-3)	2.11	5,765		7,728	7,728	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FOHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FOHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	2.11	5,765			7,728	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)					553,169	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)						11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)					553,169	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)					1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)					196,204	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)					505,503	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)					701,707	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)						17
18	SUBTRACT LINE 17 FROM LINE 16					701,707	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)					701,707	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)					1,254,876	20

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-8504

WORKSHEET M-3

CHECK RHC I TITLE V TITLE XIX
 APPLICABLE BOXES: FQHC TITLE XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	1,254,876	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	3,353	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	1,251,523	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	7,728	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	7,728	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	161.95	7

		CALCULATION OF LIMIT (1)		(SEE INSTR.)	
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1		
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	161.95	161.95	161.95	9
CALCULATION OF SETTLEMENT					
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)	1,206	1,206		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)	195,312	195,312		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		390,624		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		181,412		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)				16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)				16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		293,815		16.04
16.05	TOTAL PROGRAM COST (see instructions)		293,815		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		23,355		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		48,118		19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		293,815		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		1,734		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		295,549		22
23	ALLOWABLE BAD DEBTS (see instructions)				23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		295,549		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		5,911		26.01
27	INTERIM PAYMENTS		285,519		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		4,119		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2		5,628		30

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

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-8504

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	537,428	537,428	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000000	0.000976	2
3	PNEUMOCOCCAL AND INFLUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)		525	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (from your records)		953	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)		1,478	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	553,169	553,169	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	701,707	701,707	7
8	RATIO OF PNEUMOCOCCAL AND INFLUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)		0.002672	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)		1,875	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)		3,353	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)		87	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)		38.54	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES		45	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (line 12 x line 13)		1,734	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		3,353	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,734	16

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MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	59.73		7.29				67.02	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	4.33	26.42	2.80				33.55	50
53	ANESTHESIOLOGY	7.20	31.86	2.34				41.40	53
54	RADIOLOGY-DIAGNOSTIC	5.51	36.24	1.68				43.23	54
60	LABORATORY	9.13	36.37	1.75				47.25	60
65	RESPIRATORY THERAPY	21.41	14.49	2.52				38.42	65
66	PHYSICAL THERAPY	3.14	27.51	0.09				30.74	66
69	ELECTROCARDIOLOGY	19.75	18.72	1.01				39.48	69
71	MEDICAL SUPPLIES CHARGED TO PAT	25.13	37.61	5.56				68.30	71
73	DRUGS CHARGED TO PATIENTS	17.00	38.90	2.63				58.53	73
73.01	CARDIAC REHABILITATION		39.90					39.90	73.01
91	EMERGENCY	1.28	31.59	1.26				34.13	91
92	OBSERVATION BEDS (NON-DISTINCT		47.06					47.06	92
200	TOTAL CHARGES	8.61	33.26	1.81				43.68	200

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MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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REPORT 97 - UTILIZATION STATISTICS - SWING-BED SNF / NF

COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THRD PARTY UTIL	
	PART A	PART B	INPATIENT	OUTPAT-IENT	INPATIENT	OUTPAT-IENT		
	1	2	3	4	5	6	7	
UTILIZATION PERCENTAGES BASED ON CHARGES								
54 RADIOLOGY-DIAGNOSTIC	0.79						0.79	54
60 LABORATORY	4.21						4.21	60
65 RESPIRATORY THERAPY	12.39						12.39	65
66 PHYSICAL THERAPY	10.27						10.27	66
69 ELECTROCARDIOLOGY	2.28						2.28	69
71 MEDICAL SUPPLIES CHARGED TO PAT	11.59						11.59	71
73 DRUGS CHARGED TO PATIENTS	17.00						17.00	73
200 TOTAL CHARGES	4.67						4.67	200

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MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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REPORT 98 - COST ALLOCATION SUMMARY

COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
	1	2	3	4	5	6	
GENERAL SERVICE COST CENTERS							
1 CAP REL COSTS-BLDG & FIXT	508,055	3.33	-508,055	-6.24			1
1.01 2008 BLDG & FIXT	496,975	3.25	-496,975	-6.11			1.01
1.02 RHC BLDG & FIXT	34,255	0.22	-34,255	-0.42			1.02
2 CAP REL COSTS-MVBLE EQUIP	261,641	1.71	-261,641	-3.22			2
2.01 2008 MVBLE EQUIP	62,366	0.41	-62,366	-0.77			2.01
2.02 RHC MVBLE EQUIP	1,695	0.01	-1,695	-0.02			2.02
3 OTHER CAP REL COSTS							3
4 EMPLOYEE BENEFITS DEPARTMENT	2,121,244	13.88	-2,121,244	-26.07			4
5 ADMINISTRATIVE & GENERAL	1,857,553	12.16	-1,857,553	-22.83			5
6 MAINTENANCE & REPAIRS	300,621	1.97	-300,621	-3.69			6
7 OPERATION OF PLANT	227,739	1.49	-227,739	-2.80			7
8 LAUNDRY & LINEN SERVICE	59,833	0.39	-59,833	-0.74			8
9 HOUSEKEEPING	270,777	1.77	-270,777	-3.33			9
10 DIETARY	174,844	1.14	-174,844	-2.15			10
11 CAFETERIA	135,739	0.89	-135,739	-1.67			11
13 NURSING ADMINISTRATION	442,220	2.89	-442,220	-5.43			13
14 CENTRAL SERVICES & SUPPLY							14
15 PHARMACY	869,960	5.69	-869,960	-10.69			15
16 MEDICAL RECORDS & LIBRARY	253,336	1.66	-253,336	-3.11			16
17 SOCIAL SERVICE	58,702	0.38	-58,702	-0.72			17
INPATIENT ROUTINE SERVICE COST CENTERS							
30 ADULTS & PEDIATRICS	1,091,248	7.14	2,534,298	31.14	3,625,546	23.73	30
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	230,594	1.51	527,753	6.49	758,347	4.96	50
53 ANESTHESIOLOGY	240,000	1.57	44,666	0.55	284,666	1.86	53
54 RADIOLOGY-DIAGNOSTIC	887,558	5.81	506,239	6.22	1,393,797	9.12	54
60 LABORATORY	680,346	4.45	476,901	5.86	1,157,247	7.37	60
65 RESPIRATORY THERAPY	268,640	1.76	227,553	2.80	496,193	3.25	65
66 PHYSICAL THERAPY	586,815	3.84	438,455	5.39	1,025,270	6.71	66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	31,231	0.20	15,504	0.19	46,735	0.31	69
71 MEDICAL SUPPLIES CHARGED TO PATIENTS	571,292	3.74	106,321	1.31	677,613	4.44	71
73 DRUGS CHARGED TO PATIENTS			1,176,613	14.46	1,176,613	7.70	73
73.01 CARDIAC REHABILITATION	46,139	0.30	50,887	0.63	97,026	0.64	73.01
76.97 CARDIAC REHABILITATION							76.97
88 RURAL HEALTH CLINIC	749,373	4.90	505,503	6.21	1,254,876	8.21	88
91 EMERGENCY	960,226	6.28	784,245	9.64	1,744,471	11.42	91
92 OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			11,636	0.14	11,636	0.08	190
192 PHYSICIANS' PRIVATE OFFICES	616,549	4.04	428,672	5.27	1,045,221	6.84	192
192.0 INDEPENDENT LIVING	181,012	1.18	282,665	3.47	463,677	3.03	192.0
2 MEALS ON WHEELS			19,644	0.24	19,644	0.15	192.0
3							3
200 CROSS FOOT ADJUSTMENTS							200
201 NEGATIVE COST CENTER							201
202 TOTAL	15,278,578	100.00			15,278,578	100.00	202

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MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	Non CMS worksheet CMS-2552-10	Period : From: 07/01/2013 To: 06/30/2014	Run Date: 11/24/2014 Run Time: 10:30 Version: 2014.10
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REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

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

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

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

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES				Clinic Name Marshall Browning Physician Clinic 14-8504	Reporting Period FROM: 7/1/13 TO: 6/30/14		Attachment #1
Cost Center (OMIT COSTS)	COMPENSATION 1	OTHER 2	TOTAL COL. 1 & 2 3		RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE COL. 3 & 4 5	
1 SUPPLEMENTAL COSTS			NONE				
2 Pharmacy			-	-			-
3 Patient Transportation			-	-			-
4 Medical Case Management			-	-			-
5 Health Education			-	-			-
6 Nutrition Counseling			-	-			-
7 Others (Specify)			-	-			-
8			-	-			-
9			-	-			-
10			-	-			-
11			-	-			-
12 Supplemental Subtotal (sum of lines 2 through 11)			-	-			-
13 DENTAL			-	-			-
14 NON-ALLOWABLE COST CENTERS			-	-			-
15 FMMHC Case Management			-	-			-
16 WIC (Women, Infants & Children)			-	-			-
17 Fundraising & Public Relations			-	-			-
18 Social Services			-	-			-
19 Unlicensed Social Workers			-	-			-
20 Others (Specify)			-	-			-
21			-	-			-
22			-	-			-
23			-	-			-
24			-	-			-
25 Non-Allowable Subtotal (sum of lines 15-24)			-	-			-
26 Totals for schedule C (sum of lines 12, 13 & 25)			-	-			-

NOTE: This schedule allows for supplemental reimbursement of some costs which are not allowable under the Medicare program.

RURAL HEALTH CENTER DENTAL STATISTICS		CLINIC NAME		REPORTING PERIOD			ATTACHMENT #2
		Marshall Browning Physician Clinic 14-8504		FROM: 7/01/13 TO: 6/30/14			
COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	Col 1 & 2 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE (COL. 3 & 4) 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES (COL. 5 & 6) 7
1 RHC DENTAL STAFF COST			NONE				
2 Dentists							
3 Dental Hygienist							
4							
5							
6 TOTAL - DENTISTS (Sum on lines 1 through 5)							
7 Other - Dental Staff							
8							
9							
10							
11 SUBTOTAL - Other Dental Staff (Sum of lines 7-10)							
12 TOTAL - Dental Staff (Sum of lines 6 and 11)							
13 Dental Services Under Agreement							
14							
15 TOTAL DENTAL COST (Sum of lines 12 through 14)							

DENTAL SERVICES PERSONNEL, EQUIVALENTS, HOURS ON SITE, AND ENCOUNTERS

DENTAL SERVICES PERSONNEL	FULL TIME PERSONNEL EQUIVALENTS (FTEs)	HEALTH SERVICES HOURS	ENCOUNTERS	
			ON-SITE	OFF-SITE
16 RHC DENTAL STAFF				
17 Dentists	1	2	3	4
18 Dental Hygienist				
19				
20				
21 TOTAL - Dentists (Sum of line 17 through 20)				
22 Other - Dental Staff				
23				
24				
25				
26 SUBTOTAL - Other Dental Staff (Sum of lines 22 through 25)				
27 TOTAL - Dental Staff (Sum of lines 21 and 26)				
28 Dental Services Under Agreement				
29				
30 TOTAL DENTAL (Sum of lines 27 through 29)				

NOTE: Total dental cost from line 15, column 7, must agree with Attachment #1, line 13