DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY **WORKSHEET S PARTS I, II & III**

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 09/11/2015 Time: 14:33 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by DR JOHN WARNER HOSPITAL (14-1303) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 05/01/2014 and ending 04/30/2015, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

`
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		52,142	71,534		42,192	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-34				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			21,879			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		52,108	93,413		42,192	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 resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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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: 422 WEST WHITE STREET	P.O. Box:		1
2	City: CLINTON	State: IL	ZIP Code: 61727	County: DEWITT 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	DR JOHN WARNER HOSPITAL	14-1303	99914	1	03 / 01 / 2000	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	SWING BED	14-Z303	99914		03 / 01 / 2000	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	RURAL HEALTH CENTER	14-3404	99914		07 / 03 / 1995	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 05 / 01 / 2014	To: 04 / 30 / 2015	20
21	Type of control (see instructions)	12		21

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	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 Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci 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 reseived HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				76

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

		1	2	
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)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	Y		108

		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	Y	Y	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, Section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		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:	115,989	11,090		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121

Transplant Center Information				
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129
130	If this is a Medicare cetfified 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 cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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WORKSHEET S-2
PART I

All Providers

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

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

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

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

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

Multicampus

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

	Name	County	State	ZIP Code	CBSA	FTE/Campus	
	0	1	2	3	4	5	

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1,056,606			168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2014	09 / 30 / 2014	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? 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	08/15/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for 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 instructinos.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/10/2015	Y	07/10/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	Y		Y		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	Y	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	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render servcies to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	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	19	7,951	17,940.00		567	21	754	1
2	HMO and other (see instructions)						76			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						86		86	5
6	Hospital Adults & Peds. Swing Bed NF								3	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		19	7,951	17,940.00		653	21	843	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)		19	7,951	17,940.00		653	21	843	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							9,813	26
27	Total (sum of lines 14-26)		19							27
28	Observation Bed Days							24	165	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	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)					157	7	218	1
2	HMO and other (see instructions)					21			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)		107.89			157	7	218	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		15.38						26
27	Total (sum of lines 14-26)		123.27						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	03/01/2000	2

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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

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

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. 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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA **COMPONENT CCN: 14-3404** **WORKSHEET S-8**

Check applicable box: **[XX] RHC** **[ ] FQHC**

Clinic Address and Identification:

1	Street: 422 W WHITE STREET	1
2	City: CLINTON State: IL ZIP Code: 61727 County: DEWITT	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

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

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

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0730	1700	0730	1700	0730	1800	0730	1800	0730	1700	0900	1200	11

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

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	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 Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.522113	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,317,559	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	5,539,178	6
7	Medicaid cost (line 1 times line 6)	2,892,077	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.	574,518	8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig 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)	574,518	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	283,315	65,544	348,859	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	147,922	34,221	182,143	21
22	Partial payment by patients approved for charity care	16,393	8,016	24,409	22
23	Cost of charity care (line 21 minus line 22)	131,529	26,205	157,734	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)	1,450,026	26
27	Medicare bad debts for the entire hospital complex (see instructions)	141,377	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,308,649	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	683,263	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	840,997	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,415,515	31

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		367,615	367,615	87,813	455,428	-4,057	451,371	1
2	00200	Cap Rel Costs-Mvble Equip		677,866	677,866	9,060	686,926	-350,985	335,941	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		1,797,632	1,797,632		1,797,632		1,797,632	4
5	00500	Administrative & General	928,331	1,202,545	2,130,876	76,931	2,207,807	-21,738	2,186,069	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	177,411	474,089	651,500		651,500		651,500	7
8	00800	Laundry & Linen Service	4,783	100,540	105,323		105,323		105,323	8
9	00900	Housekeeping	94,369	31,222	125,591		125,591		125,591	9
10	01000	Dietary	144,455	128,591	273,046	-24,531	248,515	-150,854	97,661	10
11	01100	Cafeteria				24,531	24,531	-12,042	12,489	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	156,044	5,927	161,971		161,971	-1,935	160,036	13
14	01400	Central Services & Supply	17,197	110,376	127,573	-109,745	17,828		17,828	14
15	01500	Pharmacy	122,325	583,279	705,604	-224,796	480,808	-59,114	421,694	15
16	01600	Medical Records & Library	126,089	49,019	175,108		175,108	-4,081	171,027	16
17	01700	Social Service	39,617	2,271	41,888		41,888		41,888	17
19	01900	Nonphysician Anesthetists				160,620	160,620		160,620	19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	615,327	200,828	816,155	-49,363	766,792	-117,360	649,432	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	234,411	136,350	370,761		370,761	-88,700	282,061	50
53	05300	Anesthesiology		164,797	164,797	-160,620	4,177		4,177	53
54	05400	Radiology-Diagnostic	227,126	611,639	838,765		838,765	-354	838,411	54
60	06000	Laboratory	341,917	560,578	902,495	3,231	905,726	-1,587	904,139	60
62	06200	Whole Blood & Packed Red Blood Cells				2,708	2,708		2,708	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy				80,685	80,685		80,685	64
65	06500	Respiratory Therapy	181,720	55,551	237,271	-19,798	217,473	-588	216,885	65
66	06600	Physical Therapy	18,583	464,724	483,307	-18,499	464,808	-9,079	455,729	66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology	43,831	22,973	66,804		66,804	-27,806	38,998	69
71	07100	Medical Supplies Charged to Patients				129,543	129,543	-1,372	128,171	71
72	07200	Impl. Dev. Charged to Patients		56,848	56,848		56,848		56,848	72
73	07300	Drugs Charged to Patients				224,796	224,796	-5,636	219,160	73
76	03950	CARDIAC REHAB	50,101	2,530	52,631		52,631		52,631	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	1,053,332	222,299	1,275,631	-121,925	1,153,706	-18,086	1,135,620	88
90	09000	Clinic				10,155	10,155		10,155	90
90.01	09001	PROVIDER BASED CLINIC								90.01
91	09100	Emergency	638,215	890,387	1,528,602	-28,705	1,499,897		1,499,897	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		70,590	70,590	-70,590				113
118		SUBTOTALS (sum of lines 1-117)	5,215,184	8,991,066	14,206,250	-18,499	14,187,751	-875,374	13,312,377	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices	59,095	3,579	62,674		62,674		62,674	192
192.01	19201	LIFELINE								192.01
192.02	19202	HOME MEDICAL EQUIPMENT								192.02
192.03	19203	COMMUNITY BENEFIT				18,499	18,499		18,499	192.03
192.04	19204	RENTAL PROPERTIES								192.04
200		TOTAL (sum of lines 118-199)	5,274,279	8,994,645	14,268,924		14,268,924	-875,374	13,393,550	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COSTS FROM DIET	A	Cafeteria	11	12,978	11,553	1
500	Total reclassifications				12,978	11,553	500
	Code Letter - A						
1	TO RECLASS DRUGS SOLD TO PATIENTS	B	Drugs Charged to Patients	73		224,796	1
500	Total reclassifications					224,796	500
	Code Letter - B						
1	TO RECLASS INTEREST EXPENSE	C	Cap Rel Costs-Bldg & Fixt	1		70,590	1
500	Total reclassifications					70,590	500
	Code Letter - C						
1	TO RECLASS SUPPLIES CHARGED TO PTS	D	Medical Supplies Charged to P	71		109,745	1
500	Total reclassifications					109,745	500
	Code Letter - D						
1	TO RECLASS ER PHYSICIAN CONTRACTED	E	Administrative & General	5		3,387	1
500	Total reclassifications					3,387	500
	Code Letter - E						
1	TO RECLSS PROPERTY INS EXP	F	Other Cap Rel Costs	3		26,283	1
500	Total reclassifications					26,283	500
	Code Letter - F						
1	TO RECLASS RHC ADMIN EXPENSES	G	Administrative & General	5		32,188	1
500	Total reclassifications					32,188	500
	Code Letter - G						
1	TO RECLASS OXYGEN SUPPLIES	H	Medical Supplies Charged to P	71		19,798	1
500	Total reclassifications					19,798	500
	Code Letter - H						
1	TO RECLASS NURSING COST	I	Intravenous Therapy	64	80,685		1
2			Whole Blood & Packed Red Bloo	62	2,708		2
3			Clinic	90	10,155		3
500	Total reclassifications				93,548		500
	Code Letter - I						
1	TO RECLASS GRANT EXPENSES	J	Adults & Pediatrics	30		3,800	1
2			Rural Health Clinic	88		16,192	2
3			Emergency	91		15,067	3
500	Total reclassifications					35,059	500
	Code Letter - J						
1	TO RECLASS RHC PHYSICIAN ADMIN	K	Administrative & General	5	102,698		1
500	Total reclassifications				102,698		500
	Code Letter - K						
1	TO RECLASS ATHLETIC TRAINER COM BEN	L	COMMUNITY BENEFIT	192.03		18,499	1
500	Total reclassifications					18,499	500
	Code Letter - L						
1	TO RECLASS CRNA EXPENSE	M	Nonphysician Anesthetists	19		160,620	1
500	Total reclassifications					160,620	500
	Code Letter - M						
1	TO RECLASS RHC LAB TESTS	N	Laboratory	60		3,231	1
500	Total reclassifications					3,231	500
	Code Letter - N						
	GRAND TOTAL (Increases)				209,224	715,749	

(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 FROM DIET	A	Dietary	10	12,978	11,553		1
500	Total reclassifications				12,978	11,553		500
	Code letter - A							
1	TO RECLASS DRUGS SOLD TO PATIENTS	B	Pharmacy	15		224,796		1
500	Total reclassifications					224,796		500
	Code letter - B							
1	TO RECLASS INTEREST EXPENSE	C	Interest Expense	113		70,590	11	1
500	Total reclassifications					70,590		500
	Code letter - C							
1	TO RECLASS SUPPLIES CHARGED TO PTS	D	Central Services & Supply	14		109,745		1
500	Total reclassifications					109,745		500
	Code letter - D							
1	TO RECLASS ER PHYSICIAN CONTRACTED	E	Emergency	91		3,387		1
500	Total reclassifications					3,387		500
	Code letter - E							
1	TO RECLSS PROPERTY INS EXP	F	Administrative & General	5		26,283	12	1
500	Total reclassifications					26,283		500
	Code letter - F							
1	TO RECLASS RHC ADMIN EXPENSES	G	Rural Health Clinic	88		32,188		1
500	Total reclassifications					32,188		500
	Code letter - G							
1	TO RECLASS OXYGEN SUPPLIES	H	Respiratory Therapy	65		19,798		1
500	Total reclassifications					19,798		500
	Code letter - H							
1	TO RECLASS NURSING COST	I	Adults & Pediatrics	30	53,163			1
2			Emergency	91	40,385			2
3								3
500	Total reclassifications				93,548			500
	Code letter - I							
1	TO RECLASS GRANT EXPENSES	J	Administrative & General	5		35,059		1
2								2
3								3
500	Total reclassifications					35,059		500
	Code letter - J							
1	TO RECLASS RHC PHYSICIAN ADMIN	K	Rural Health Clinic	88	102,698			1
500	Total reclassifications				102,698			500
	Code letter - K							
1	TO RECLASS ATHLETIC TRAINER COM BEN	L	Physical Therapy	66		18,499		1
500	Total reclassifications					18,499		500
	Code letter - L							
1	TO RECLASS CRNA EXPENSE	M	Anesthesiology	53		160,620		1
500	Total reclassifications					160,620		500
	Code letter - M							
1	TO RECLASS RHC LAB TESTS	N	Rural Health Clinic	88		3,231		1
500	Total reclassifications					3,231		500
	Code letter - N							
	GRAND TOTAL (Decreases)				209,224	715,749		

(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.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	343,588					343,588		1
2	Land Improvements								2
3	Buildings and Fixtures	10,525,278	281,460		281,460	80,358	10,726,380		3
4	Building Improvements								4
5	Fixed Equipment	133,362				7,590	125,772		5
6	Movable Equipment	5,169,219	957,091		957,091	1,474,358	4,651,952		6
7	HIT-designated Assets		1,056,607		1,056,607		1,056,607		7
8	Subtotal (sum of lines 1-7)	16,171,447	2,295,158		2,295,158	1,562,306	16,904,299		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	16,171,447	2,295,158		2,295,158	1,562,306	16,904,299		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	367,615						367,615	1
2	Cap Rel Costs-Mvble Equip	677,866						677,866	2
3	Total (sum of lines 1-2)	1,045,481						1,045,481	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

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	10,852,152		10,852,152	0.655295	17,223			17,223	1
2	Cap Rel Costs-Mvble Equ	5,708,558		5,708,558	0.344705	9,060			9,060	2
3	Total (sum of lines 1-2)	16,560,710		16,560,710	1.000000	26,283			26,283	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	367,615		66,533	17,223			451,371	1
2	Cap Rel Costs-Mvble Equip	326,881			9,060			335,941	2
3	Total (sum of lines 1-2)	694,496		66,533	26,283			787,312	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**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-4,057	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)	B	-7,163	Administrative & General	5	11	3
4	Trace, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-248,376				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-354	Radiology-Diagnostic	54		11
12	Related organization transactions (chapter 10)	Wkst A-8-1	58,930				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-12,042	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-1,372	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients	B	-5,636	Drugs Charged to Patients	73		17
18	Sale of medical records and abstracts	B	-4,081	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	A	-347,673	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	OTHER INCOME	B	-14,692	Administrative & General	5		33
34	OUTSIDE DIETARY SERVICES	B	-150,854	Dietary	10		34
35							35
36	FITNESS MGMT	B	-8,480	Physical Therapy	66		36
37	OUTSIDE LAB SERVICES	B	-1,587	Laboratory	60		37
38	OUTSIDE SURGICAL SERVICES	B	-700	Operating Room	50		38
39	OTHER REVENUE - RHC	B	-2,876	Rural Health Clinic	88		39
40	RESTING METABOLIC	B	-588	Respiratory Therapy	65		40
41	LOBBYING EXPENSE	A	-7,350	Administrative & General	5		41
42	ADVERTISING EXPENSE	A	-31,485	Administrative & General	5		42
43	MARKETING OTHER EXPENSE	A	-17,676	Administrative & General	5		43
44	CLINICAL TRAINING CLASSES	A	-1,935	Nursing Administration	13		44
45	NON-ALLOW CONTRIB/HELIPAD	A	-2,302	Administrative & General	5		45
46	NON-ALLOW PURCH SVC - CABLE TV	A	-599	Physical Therapy	66		46
47	DEPRECIATION ON NON-ALLOW CABLE TV	A	-3,312	Cap Rel Costs-Mvble Equip	2	9	47
48	340B PROGRAM	A	-59,114	Pharmacy	15		48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-875,374				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	5	Administrative & General	ADMINISTRATION & GENERAL	58,930		58,930		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			58,930		58,930		5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			CITY OF CLINTON		CITY GOVERNMENT	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	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	60	Laboratory	3,002		3,002					1
2	69	Electrocardiology AGGREGATE	27,806	27,806						2
3	91	Emergency CORE	810,724		810,724					3
4	88	Rural Health Clinic AGGREGATE	511,416	15,210	496,206					4
5	50	Operating Room AGGREGATE	88,000	88,000						5
6	30	Adults & Pediatrics HOSPITALIST	117,360	117,360						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	1,558,308	248,376	1,309,932					200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	60	Laboratory								1
2	69	Electrocardiology AGGREGATE							27,806	2
3	91	Emergency CORE								3
4	88	Rural Health Clinic AGGREGATE							15,210	4
5	50	Operating Room AGGREGATE							88,000	5
6	30	Adults & Pediatrics HOSPITALIST							117,360	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							248,376	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 [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					12	1
2	Line 1 multiplied by 15 hours per week					180	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					259	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)					241	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					5.75	7
8	Optional travel expense rate					0.58	8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		3,862.50	1,955.75	1,290.75		9
10	AHSEA (see instructions)		76.49	57.37	13.78		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)	38.25	38.25	28.69			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)	295,443	15
16	Assistants (column 3, line 9 times column 3, line 10)	112,201	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	407,644	17
18	Aides (column 4, line 9 times column 4, line 10)	17,787	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)	425,431	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)	425,431	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)	9,907	24
25	Assistants (line 4 times column 3, line 11)	6,914	25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	16,821	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,875	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	19,696	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)	19,696	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	Optoinal 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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

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 V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 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 incolumn 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 overimte 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)	425,431	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	19,696	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)	445,127	63
64	Total cost of outside supplier services (from provider records)	267,545	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	451,371	451,371					1
2	Cap Rel Costs-Mvble Equip	335,941		335,941				2
4	Employee Benefits Department	1,797,632	2,709	2,016	1,802,357			4
5	Administrative & General	2,186,069	48,412	36,031	352,331	2,622,843	2,622,843	5
6	Maintenance & Repairs							6
7	Operation of Plant	651,500	87,775	65,330	60,626	865,231	210,698	7
8	Laundry & Linen Service	105,323	5,347	3,979	1,634	116,283	28,317	8
9	Housekeeping	125,591	2,651	1,973	32,248	162,463	39,562	9
10	Dietary	97,661	13,986	10,409	44,929	166,985	40,664	10
11	Cafeteria	12,489			4,435	16,924	4,121	11
12	Maintenance of Personnel							12
13	Nursing Administration	160,036	2,897	2,156	53,324	218,413	53,187	13
14	Central Services & Supply	17,828	9,119	6,787	5,877	39,611	9,646	14
15	Pharmacy	421,694	7,777	5,788	41,802	477,061	116,172	15
16	Medical Records & Library	171,027	10,071	7,496	43,088	231,682	56,418	16
17	Social Service	41,888			13,538	55,426	13,497	17
19	Nonphysician Anesthetists	160,620				160,620	39,114	19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	649,432	54,400	40,488	192,106	936,426	228,035	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	282,061	31,108	23,153	80,104	416,426	101,406	50
53	Anesthesiology	4,177	1,160	863		6,200	1,510	53
54	Radiology-Diagnostic	838,411	32,145	23,924	77,615	972,095	236,721	54
60	Laboratory	904,139	10,849	8,075	116,842	1,039,905	253,234	60
62	Whole Blood & Packed Red Blood Cells	2,708			925	3,633	885	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	80,685			27,572	108,257	26,362	64
65	Respiratory Therapy	216,885	2,016	1,500	62,098	282,499	68,793	65
66	Physical Therapy	455,729	16,286	12,121	6,350	490,486	119,441	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	38,998	1,594	1,187	14,978	56,757	13,821	69
71	Medical Supplies Charged to Patients	128,171				128,171	31,212	71
72	Impl. Dev. Charged to Patients	56,848				56,848	13,843	72
73	Drugs Charged to Patients	219,160				219,160	53,369	73
76	CARDIAC REHAB	52,631	1,938	1,442	17,121	73,132	17,809	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,135,620	55,638	41,410	324,856	1,557,524	379,282	88
90	Clinic	10,155			3,470	13,625	3,318	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	1,499,897	23,882	17,775	204,294	1,745,848	425,144	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	13,312,377	421,760	313,903	1,782,163	13,240,534	2,585,581	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	62,674	29,611	22,038	20,194	134,517	32,757	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT	18,499				18,499	4,505	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	13,393,550	451,371	335,941	1,802,357	13,393,550	2,622,843	202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,075,929						7
8	Laundry & Linen Service	18,410	163,010					8
9	Housekeeping	9,127		211,152				9
10	Dietary	48,156		9,699	265,504			10
11	Cafeteria					21,045		11
12	Maintenance of Personnel							12
13	Nursing Administration	9,975		2,009		859	284,443	13
14	Central Services & Supply	31,398		6,324		95		14
15	Pharmacy	26,778		5,393		674		15
16	Medical Records & Library	34,678		6,984		694		16
17	Social Service					218	6,990	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	187,314	163,010	37,726	265,504	3,095	105,701	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	107,113		21,573		1,291	27,616	50
53	Anesthesiology	3,994		804				53
54	Radiology-Diagnostic	110,684		22,292		1,251		54
60	Laboratory	37,356		7,524		1,883		60
62	Whole Blood & Packed Red Blood Cells					15		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					444		64
65	Respiratory Therapy	6,940		1,398		1,001		65
66	Physical Therapy	56,078		11,294		102		66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	5,490		1,106		241		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	6,672		1,344		276	8,707	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	191,576		38,585		5,233	32,028	88
90	Clinic					56		90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	82,232		16,562		3,292	103,401	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	973,971	163,010	190,617	265,504	20,720	284,443	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	101,958		20,535		325		192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,075,929	163,010	211,152	265,504	21,045	284,443	202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	
		14	15	16	17	19	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	87,074						14
15	Pharmacy	432	626,510					15
16	Medical Records & Library	13		330,469				16
17	Social Service				76,131			17
19	Nonphysician Anesthetists					199,734		19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,399		13,192	76,131		2,019,533	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,121		11,279			690,825	50
53	Anesthesiology	150		6,556		199,734	218,948	53
54	Radiology-Diagnostic	7,559		77,054			1,427,656	54
60	Laboratory	29,135		58,709			1,427,746	60
62	Whole Blood & Packed Red Blood Cells			377			4,910	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			17,795			152,858	64
65	Respiratory Therapy	763		7,173			368,567	65
66	Physical Therapy	883		33,979			712,263	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	258		6,152			83,825	69
71	Medical Supplies Charged to Patients	21,433		6,697			187,513	71
72	Impl. Dev. Charged to Patients	11,103		1,326			83,120	72
73	Drugs Charged to Patients		626,510	18,001			917,040	73
76	CARDIAC REHAB	199		2,032			110,171	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,394		27,334			2,232,956	88
90	Clinic	126		1,170			18,295	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	6,106		41,643			2,424,228	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	87,074	626,510	330,469	76,131	199,734	13,080,454	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						290,092	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						23,004	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	87,074	626,510	330,469	76,131	199,734	13,393,550	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,019,533					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		690,825					50
53	Anesthesiology		218,948					53
54	Radiology-Diagnostic		1,427,656					54
60	Laboratory		1,427,746					60
62	Whole Blood & Packed Red Blood Cells		4,910					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		152,858					64
65	Respiratory Therapy		368,567					65
66	Physical Therapy		712,263					66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		83,825					69
71	Medical Supplies Charged to Patients		187,513					71
72	Impl. Dev. Charged to Patients		83,120					72
73	Drugs Charged to Patients		917,040					73
76	CARDIAC REHAB		110,171					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		2,232,956					88
90	Clinic		18,295					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		2,424,228					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		13,080,454					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		290,092					192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT		23,004					192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		13,393,550					202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		2,709	2,016	4,725	4,725		4
5	Administrative & General		48,412	36,031	84,443	922	85,365	5
6	Maintenance & Repairs							6
7	Operation of Plant		87,775	65,330	153,105	159	6,858	7
8	Laundry & Linen Service		5,347	3,979	9,326	4	922	8
9	Housekeeping		2,651	1,973	4,624	85	1,288	9
10	Dietary		13,986	10,409	24,395	118	1,324	10
11	Cafeteria					12	134	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,897	2,156	5,053	140	1,731	13
14	Central Services & Supply		9,119	6,787	15,906	15	314	14
15	Pharmacy		7,777	5,788	13,565	110	3,781	15
16	Medical Records & Library		10,071	7,496	17,567	113	1,836	16
17	Social Service					35	439	17
19	Nonphysician Anesthetists						1,273	19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		54,400	40,488	94,888	504	7,422	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		31,108	23,153	54,261	210	3,301	50
53	Anesthesiology		1,160	863	2,023		49	53
54	Radiology-Diagnostic		32,145	23,924	56,069	204	7,705	54
60	Laboratory		10,849	8,075	18,924	306	8,242	60
62	Whole Blood & Packed Red Blood Cells					2	29	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					72	858	64
65	Respiratory Therapy		2,016	1,500	3,516	163	2,239	65
66	Physical Therapy		16,286	12,121	28,407	17	3,888	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		1,594	1,187	2,781	39	450	69
71	Medical Supplies Charged to Patients						1,016	71
72	Impl. Dev. Charged to Patients						451	72
73	Drugs Charged to Patients						1,737	73
76	CARDIAC REHAB		1,938	1,442	3,380	45	580	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		55,638	41,410	97,048	852	12,345	88
90	Clinic					9	108	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		23,882	17,775	41,657	536	13,832	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		421,760	313,903	735,663	4,672	84,152	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		29,611	22,038	51,649	53	1,066	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						147	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		451,371	335,941	787,312	4,725	85,365	202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	160,122						7
8	Laundry & Linen Service	2,740	12,992					8
9	Housekeeping	1,358		7,355				9
10	Dietary	7,167		338	33,342			10
11	Cafeteria					146		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,484		70		6	8,484	13
14	Central Services & Supply	4,673		220		1		14
15	Pharmacy	3,985		188		5		15
16	Medical Records & Library	5,161		243		5		16
17	Social Service					2	208	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	27,876	12,992	1,314	33,342	21	3,153	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	15,941		751		9	824	50
53	Anesthesiology	594		28				53
54	Radiology-Diagnostic	16,472		777		9		54
60	Laboratory	5,559		262		13		60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					3		64
65	Respiratory Therapy	1,033		49		7		65
66	Physical Therapy	8,346		393		1		66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	817		39		2		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	993		47		2	260	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	28,511		1,344		35	955	88
90	Clinic							90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	12,238		577		23	3,084	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	144,948	12,992	6,640	33,342	144	8,484	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	15,174		715		2		192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	160,122	12,992	7,355	33,342	146	8,484	202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	
		14	15	16	17	19	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	21,129						14
15	Pharmacy	105	21,739					15
16	Medical Records & Library	3		24,928				16
17	Social Service				684			17
19	Nonphysician Anesthetists					1,273		19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	825		995	684		184,016	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,000		851			77,148	50
53	Anesthesiology	36		495			3,225	53
54	Radiology-Diagnostic	1,834		5,814			88,884	54
60	Laboratory	7,070		4,428			44,804	60
62	Whole Blood & Packed Red Blood Cells			28			59	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			1,342			2,275	64
65	Respiratory Therapy	185		541			7,733	65
66	Physical Therapy	214		2,563			43,829	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	63		464			4,655	69
71	Medical Supplies Charged to Patients	5,201		505			6,722	71
72	Impl. Dev. Charged to Patients	2,694		100			3,245	72
73	Drugs Charged to Patients		21,739	1,358			24,834	73
76	CARDIAC REHAB	48		153			5,508	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	338		2,062			143,490	88
90	Clinic	31		88			236	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	1,482		3,141			76,570	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	21,129	21,739	24,928	684		717,233	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						68,659	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						147	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments					1,273	1,273	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,129	21,739	24,928	684	1,273	787,312	202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		184,016					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		77,148					50
53	Anesthesiology		3,225					53
54	Radiology-Diagnostic		88,884					54
60	Laboratory		44,804					60
62	Whole Blood & Packed Red Blood Cells		59					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		2,275					64
65	Respiratory Therapy		7,733					65
66	Physical Therapy		43,829					66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		4,655					69
71	Medical Supplies Charged to Patients		6,722					71
72	Impl. Dev. Charged to Patients		3,245					72
73	Drugs Charged to Patients		24,834					73
76	CARDIAC REHAB		5,508					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		143,490					88
90	Clinic		236					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		76,570					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		717,233					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		68,659					192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT		147					192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments		1,273					200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		787,312					202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	69,647						1
2	Cap Rel Costs-Mvble Equip		69,647					2
4	Employee Benefits Department	418	418	5,274,279				4
5	Administrative & General	7,470	7,470	1,031,029	-2,622,843	10,770,707		5
6	Maintenance & Repairs							6
7	Operation of Plant	13,544	13,544	177,411		865,231	48,215	7
8	Laundry & Linen Service	825	825	4,783		116,283	825	8
9	Housekeeping	409	409	94,369		162,463	409	9
10	Dietary	2,158	2,158	131,477		166,985	2,158	10
11	Cafeteria			12,978		16,924		11
12	Maintenance of Personnel							12
13	Nursing Administration	447	447	156,044		218,413	447	13
14	Central Services & Supply	1,407	1,407	17,197		39,611	1,407	14
15	Pharmacy	1,200	1,200	122,325		477,061	1,200	15
16	Medical Records & Library	1,554	1,554	126,089		231,682	1,554	16
17	Social Service			39,617		55,426		17
19	Nonphysician Anesthetists					160,620		19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,394	8,394	562,164		936,426	8,394	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,800	4,800	234,411		416,426	4,800	50
53	Anesthesiology	179	179			6,200	179	53
54	Radiology-Diagnostic	4,960	4,960	227,126		972,095	4,960	54
60	Laboratory	1,674	1,674	341,917		1,039,905	1,674	60
62	Whole Blood & Packed Red Blood Cells			2,708		3,633		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			80,685		108,257		64
65	Respiratory Therapy	311	311	181,720		282,499	311	65
66	Physical Therapy	2,513	2,513	18,583		490,486	2,513	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	246	246	43,831		56,757	246	69
71	Medical Supplies Charged to Patients					128,171		71
72	Impl. Dev. Charged to Patients					56,848		72
73	Drugs Charged to Patients					219,160		73
76	CARDIAC REHAB	299	299	50,101		73,132	299	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	8,585	8,585	950,634		1,557,524	8,585	88
90	Clinic			10,155		13,625		90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	3,685	3,685	597,830		1,745,848	3,685	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	65,078	65,078	5,215,184	-2,622,843	10,617,691	43,646	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,569	4,569	59,095		134,517	4,569	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT					18,499		192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	451,371	335,941	1,802,357		2,622,843	1,075,929	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.480839	4.823481	0.341726		0.243516	22.315234	203
204	Cost to be allocated (Per Wkst. B, Part II)			4,725		85,365	160,122	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000896		0.007926	3.321000	205

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINIS-TRATION DIRECT NRSG SALAR	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	754						8
9	Housekeeping		46,981					9
10	Dietary		2,158	754				10
11	Cafeteria				3,822,232			11
12	Maintenance of Personnel							12
13	Nursing Administration		447		156,044	1,631,878		13
14	Central Services & Supply		1,407		17,197		445,843	14
15	Pharmacy		1,200		122,325		2,210	15
16	Medical Records & Library		1,554		126,089		68	16
17	Social Service				39,617	40,100		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	754	8,394	754	562,164	606,415	17,403	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		4,800		234,411	158,436	21,100	50
53	Anesthesiology		179				768	53
54	Radiology-Diagnostic		4,960		227,126		38,704	54
60	Laboratory		1,674		341,917		149,184	60
62	Whole Blood & Packed Red Blood Cells				2,708			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy				80,685			64
65	Respiratory Therapy		311		181,720		3,905	65
66	Physical Therapy		2,513		18,583		4,519	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		246		43,831		1,321	69
71	Medical Supplies Charged to Patients						109,745	71
72	Impl. Dev. Charged to Patients						56,848	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB		299		50,101	49,955	1,020	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		8,585		950,634	183,747	7,139	88
90	Clinic				10,155		647	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		3,685		597,830	593,225	31,262	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	754	42,412	754	3,763,137	1,631,878	445,843	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		4,569		59,095			192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	163,010	211,152	265,504	21,045	284,443	87,074	202
203	Unit Cost Multiplier (Wkst. B, Part I)	216.193634	4.494413	352.127321	0.005506	0.174304	0.195302	203
204	Cost to be allocated (Per Wkst. B, Part II)	12,992	7,355	33,342	146	8,484	21,129	204
205	Unit Cost Multiplier (Wkst. B, Part II)	17.230769	0.156553	44.220159	0.000038	0.005199	0.047391	205

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	NONPHYSIC. ANESTHET. ASSIGNED TIME			
		15	16	17	19			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	524,165						15
16	Medical Records & Library		25,052,941					16
17	Social Service			754				17
19	Nonphysician Anesthetists				100			19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,000,040	754				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		855,016					50
53	Anesthesiology		497,003		100			53
54	Radiology-Diagnostic		5,841,835					54
60	Laboratory		4,450,686					60
62	Whole Blood & Packed Red Blood Cells		28,600					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		1,349,020					64
65	Respiratory Therapy		543,806					65
66	Physical Therapy		2,575,921					66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		466,380					69
71	Medical Supplies Charged to Patients		507,712					71
72	Impl. Dev. Charged to Patients		100,490					72
73	Drugs Charged to Patients	524,165	1,364,610					73
76	CARDIAC REHAB		154,014					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		2,072,146					88
90	Clinic		88,710					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		3,156,952					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	524,165	25,052,941	754	100			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	626,510	330,469	76,131	199,734			202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.195253	0.013191	100.969496	1,997.340000			203
204	Cost to be allocated (Per Wkst. B, Part II)	21,739	24,928	684	1,273			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.041474	0.000995	0.907162	12.730000			205

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,019,533		2,019,533			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	690,825		690,825			50
53	Anesthesiology	218,948		218,948			53
54	Radiology-Diagnostic	1,427,656		1,427,656			54
60	Laboratory	1,427,746		1,427,746			60
62	Whole Blood & Packed Red Blood Cells	4,910		4,910			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	152,858		152,858			64
65	Respiratory Therapy	368,567		368,567			65
66	Physical Therapy	712,263		712,263			66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology	83,825		83,825			69
71	Medical Supplies Charged to Patients	187,513		187,513			71
72	Impl. Dev. Charged to Patients	83,120		83,120			72
73	Drugs Charged to Patients	917,040		917,040			73
76	CARDIAC REHAB	110,171		110,171			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	2,232,956		2,232,956			88
90	Clinic	18,295		18,295			90
90.01	PROVIDER BASED CLINIC						90.01
91	Emergency	2,424,228		2,424,228			91
92	Observation Beds (Non-Distinct Part)	331,505		331,505			92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	13,411,959		13,411,959			200
201	Less Observation Beds	331,505		331,505			201
202	Total (line 200 minus line 201)	13,080,454		13,080,454			202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	811,388		811,388				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	104,736	750,280	855,016	0.807967			50
53	Anesthesiology	81,304	415,699	497,003	0.440537			53
54	Radiology-Diagnostic	530,292	5,311,543	5,841,835	0.244385			54
60	Laboratory	525,570	3,925,116	4,450,686	0.320792			60
62	Whole Blood & Packed Red Blood Cells	1,818	26,782	28,600	0.171678			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	114,886	1,234,134	1,349,020	0.113310			64
65	Respiratory Therapy	255,051	288,755	543,806	0.677755			65
66	Physical Therapy	23,466	2,552,455	2,575,921	0.276508			66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	70,694	395,686	466,380	0.179735			69
71	Medical Supplies Charged to Patients	227,085	280,627	507,712	0.369329			71
72	Impl. Dev. Charged to Patients	11,055	89,435	100,490	0.827147			72
73	Drugs Charged to Patients	396,099	968,511	1,364,610	0.672016			73
76	CARDIAC REHAB		154,014	154,014	0.715331			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	110,471	1,961,675	2,072,146				88
90	Clinic	1,153	87,557	88,710	0.206234			90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	195,256	2,961,696	3,156,952	0.767901			91
92	Observation Beds (Non-Distinct Part)	28,368	160,284	188,652	1.757230			92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	3,488,692	21,564,249	25,052,941				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	3,488,692	21,564,249	25,052,941				202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1303** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.807967		226,084			182,668		50
53	Anesthesiology	0.440537		133,724			58,910		53
54	Radiology-Diagnostic	0.244385		1,799,189			439,695		54
60	Laboratory	0.320792		1,652,079			529,974		60
62	Whole Blood & Packed Red Blood Cells	0.171678		17,622			3,025		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.113310		611,345			69,272		64
65	Respiratory Therapy	0.677755		101,026			68,471		65
66	Physical Therapy	0.276508		678,993			187,747		66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	0.179735		194,974			35,044		69
71	Medical Supplies Charged to Patients	0.369329		97,123			35,870		71
72	Impl. Dev. Charged to Patients	0.827147		5,534			4,577		72
73	Drugs Charged to Patients	0.672016		508,386			341,644		73
76	CARDIAC REHAB	0.715331		85,321			61,033		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.206234		46,604			9,611		90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.767901		904,022			694,199		91
92	Observation Beds (Non-Distinct Part)	1.757230		99,357			174,593		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			7,161,383			2,896,333		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			7,161,383			2,896,333		202

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z303** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.807967							50
53	Anesthesiology	0.440537							53
54	Radiology-Diagnostic	0.244385							54
60	Laboratory	0.320792							60
62	Whole Blood & Packed Red Blood Cells	0.171678							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.113310							64
65	Respiratory Therapy	0.677755							65
66	Physical Therapy	0.276508							66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	0.179735							69
71	Medical Supplies Charged to Patients	0.369329							71
72	Impl. Dev. Charged to Patients	0.827147							72
73	Drugs Charged to Patients	0.672016							73
76	CARDIAC REHAB	0.715331							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.206234							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.767901							91
92	Observation Beds (Non-Distinct Part)	1.757230							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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	184,016	15,778	168,238	919	183.07	21	3,844	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)	184,016		168,238	919		21	3,844	200

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1303** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	77,148	855,016	0.090230			50
53	Anesthesiology	3,225	497,003	0.006489			53
54	Radiology-Diagnostic	88,884	5,841,835	0.015215			54
60	Laboratory	44,804	4,450,686	0.010067			60
62	Whole Blood & Packed Red Blood Cells	59	28,600	0.002063			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	2,275	1,349,020	0.001686			64
65	Respiratory Therapy	7,733	543,806	0.014220			65
66	Physical Therapy	43,829	2,575,921	0.017015			66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology	4,655	466,380	0.009981			69
71	Medical Supplies Charged to Patients	6,722	507,712	0.013240			71
72	Impl. Dev. Charged to Patients	3,245	100,490	0.032292			72
73	Drugs Charged to Patients	24,834	1,364,610	0.018199			73
76	CARDIAC REHAB	5,508	154,014	0.035763			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	143,490	2,072,146	0.069247			88
90	Clinic	236	88,710	0.002660			90
90.01	PROVIDER BASED CLINIC						90.01
91	Emergency	76,570	3,156,952	0.024254			91
92	Observation Beds (Non-Distinct Part)	33,039	188,652	0.175132			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	566,256	24,241,553				200

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

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

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	919		21		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)	919		21		200

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1303** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] Other

(A)	Cost Center Description	Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology	199,734				199,734		53
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	199,734				199,734		200

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1303** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	855,016							50
53	Anesthesiology	497,003	0.401877						53
54	Radiology-Diagnostic	5,841,835							54
60	Laboratory	4,450,686							60
62	Whole Blood & Packed Red Blood Cells	28,600							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,349,020							64
65	Respiratory Therapy	543,806							65
66	Physical Therapy	2,575,921							66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	466,380							69
71	Medical Supplies Charged to Patients	507,712							71
72	Impl. Dev. Charged to Patients	100,490							72
73	Drugs Charged to Patients	1,364,610							73
76	CARDIAC REHAB	154,014							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	2,072,146							88
90	Clinic	88,710							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	3,156,952							91
92	Observation Beds (Non-Distinct Part)	188,652							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	24,241,553							200

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1303** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.807967							50
53	Anesthesiology	0.440537							53
54	Radiology-Diagnostic	0.244385							54
60	Laboratory	0.320792							60
62	Whole Blood & Packed Red Blood Cells	0.171678							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.113310							64
65	Respiratory Therapy	0.677755							65
66	Physical Therapy	0.276508							66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	0.179735							69
71	Medical Supplies Charged to Patients	0.369329							71
72	Impl. Dev. Charged to Patients	0.827147							72
73	Drugs Charged to Patients	0.672016							73
76	CARDIAC REHAB	0.715331							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.206234							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.767901							91
92	Observation Beds (Non-Distinct Part)	1.757230							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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/MR	[ ] PPS
	[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF		[ ] TEFRA
	[ ] Title XIX - I/P	[ ] IRF	[ ] NF		[XX] Other

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,008	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	919	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)	754	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	57	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)	29	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	2	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)	1	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	567	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)	57	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)	29	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,019,533	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)	241	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	131	25
26	Total swing-bed cost (see instructions)	173,156	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,846,377	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,846,377	37

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					2,009.12	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,139,171	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)					1,139,171	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					543,202	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,682,373	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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)					114,520	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					58,264	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					172,784	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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1**
PARTS III & IV

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)	165	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,009.12	88
89	Observation bed cost (line 87 x line 88) (see instructions)	331,505	89

		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	184,016	1,846,377	0.099663	331,505	33,039	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,008	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	919	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)	754	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	57	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)	29	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	2	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)	1	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	21	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,019,533	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)	241	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	131	25
26	Total swing-bed cost (see instructions)	173,156	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,846,377	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,846,377	37

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1303** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					2,009.12	38
39	Program general inpatient routine service cost (line 9 x line 38)					42,192	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)					42,192	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					42,192	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,844	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					3,844	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 etner 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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					165	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)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1303** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[ ] PPS
[XX] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[ ] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/MR	[XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		558,645		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.807967	38,082	30,769	50
53	Anesthesiology	0.440537	21,791	9,600	53
54	Radiology-Diagnostic	0.244385	250,527	61,225	54
60	Laboratory	0.320792	254,962	81,790	60
62	Whole Blood & Packed Red Blood Cells	0.171678			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.113310	26,490	3,002	64
65	Respiratory Therapy	0.677755	175,302	118,812	65
66	Physical Therapy	0.276508	11,044	3,054	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.179735	38,790	6,972	69
71	Medical Supplies Charged to Patients	0.369329	149,534	55,227	71
72	Impl. Dev. Charged to Patients	0.827147			72
73	Drugs Charged to Patients	0.672016	238,930	160,565	73
76	CARDIAC REHAB	0.715331			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.206234			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.767901	10,455	8,028	91
92	Observation Beds (Non-Distinct Part)	1.757230	2,366	4,158	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,218,273	543,202	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,218,273		202

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z303** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other) [XX] Swing Bed SNF [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.807967			50
53	Anesthesiology	0.440537			53
54	Radiology-Diagnostic	0.244385	8,536	2,086	54
60	Laboratory	0.320792	12,478	4,003	60
62	Whole Blood & Packed Red Blood Cells	0.171678			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.113310			64
65	Respiratory Therapy	0.677755	14,326	9,710	65
66	Physical Therapy	0.276508	9,963	2,755	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.179735	1,156	208	69
71	Medical Supplies Charged to Patients	0.369329	10,029	3,704	71
72	Impl. Dev. Charged to Patients	0.827147			72
73	Drugs Charged to Patients	0.672016	32,924	22,125	73
76	CARDIAC REHAB	0.715331			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.206234			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.767901			91
92	Observation Beds (Non-Distinct Part)	1.757230			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		89,412	44,591	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		89,412		202

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1303** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[ ] PPS
[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[XX] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/MR	[XX] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.807967			50
53	Anesthesiology	0.440537			53
54	Radiology-Diagnostic	0.244385			54
60	Laboratory	0.320792			60
62	Whole Blood & Packed Red Blood Cells	0.171678			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.113310			64
65	Respiratory Therapy	0.677755			65
66	Physical Therapy	0.276508			66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.179735			69
71	Medical Supplies Charged to Patients	0.369329			71
72	Impl. Dev. Charged to Patients	0.827147			72
73	Drugs Charged to Patients	0.672016			73
76	CARDIAC REHAB	0.715331			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.206234			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.767901			91
92	Observation Beds (Non-Distinct Part)	1.757230			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1303** **WORKSHEET E PART B**

Check applicable box: [XX] 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)	2,896,333			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,896,333			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable 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)	2,925,296			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	11,626			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,108,575			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,805,095			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,805,095			30
31	Primary payer payments	343			31
32	Subtotal (line 30 minus line 31)	1,804,752			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)	143,975			34
35	Adjusted reimbursable bad debts (see instructions)	109,421			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	143,975			36
37	Subtotal (see instructions)	1,914,173			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,914,173			40
40.01	Sequestration adjustment (see instructions)	38,283			40.01
41	Interim payments	1,804,356			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	71,534			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1303** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,562,306		1,964,032	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	04/22/2015	59,059	04/22/2015	159,676	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		-59,059		-159,676	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)				1,503,247		1,804,356	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		83,885		109,817	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,587,132		1,914,173	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.

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z303** **WORKSHEET E-1**
PART I

Check Applicable Boxes:
[ ] Hospital [ ] SUB (Other)
[ ] IPF [ ] SNF
[ ] IRF [XX] Swing Bed SNF

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				220,339			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	04/22/2015	9,052			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		-9,052			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)				211,287			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		4,277			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				215,564			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.

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	218	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	567	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	76	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	754	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	25,052,941	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	348,859	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1,056,606	7
8	Calculation of the HIT incentive payment (see instructions)	1,056,606	8
9	Sequestration adjustment amount (see instructions)	21,132	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1,035,474	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)	1,035,474	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)		32

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z303** **WORKSHEET E-2**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX** **[XX] Swing Bed - SNF** **[ ] Swing Bed - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	174,512		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 5 and 7, line 202 for Part B) (For CAH, see instructions)	45,037		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	86		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	219,549		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	219,549		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	219,549		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	3,985		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)	215,564		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	215,564		19
19.01	Sequestration adjustment (see instructions)	4,311		19.01
20	Interim payments	211,287		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-34		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, §115.2			23

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	1,682,373	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,682,373	4
5	Primary payer payments		5
6	Total cost (line 4 less line 5) (see instructions)	1,699,197	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,699,197	19
20	Deductibles (exclude professional component)	128,180	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,571,017	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,571,017	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,204	25
26	Adjusted reimbursable bad debts (see instructions)	16,115	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	21,204	27
28	Subtotal (sum of lines 24 and 26)	1,587,132	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,587,132	30
30.01	Sequestration adjustment (see instructions)	31,743	30.01
31	Interim payments	1,503,247	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	52,142	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1303** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: [ ] Title V [XX] Title XIX [XX] Hospital [ ] SUB (Other) [ ] SNF [ ] NF [ ] ICF/MR [ ] PPS [ ] TEFRA [XX] Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	42,192		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	42,192		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	42,192		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	42,192		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	42,192		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)	42,192		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)	42,192		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	42,192		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	42,192		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	42,192		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	2,598,083				1
2	Temporary investments	2,016,877				2
3	Notes receivable					3
4	Accounts receivable	4,045,869				4
5	Other receivables	277,938				5
6	Allowances for uncollectible notes and accounts receivable	-2,007,134				6
7	Inventory	304,823				7
8	Prepaid expenses	162,156				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	7,398,612				11
	FIXED ASSETS					
12	Land	343,588				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	10,726,380				15
16	Accumulated depreciation	-7,361,612				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	125,772				19
20	Accumulated depreciation	-66,932				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,651,951				23
24	Accumulated depreciation	-3,860,246				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,056,607				27
28	Accumulated depreciation	-347,673				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	5,267,835				30
	OTHER ASSETS					
31	Investments	786,211				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	376,543				34
35	Total other assets (sum of lines 31-34)	1,162,754				35
36	Total assets (sum of lines 11, 30 and 35)	13,829,201				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	553,119				37
38	Salaries, wages and fees payable	505,558				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	326,540				40
41	Deferred income	718,300				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	438,678				44
45	Total current liabilities (sum of lines 37 thru 44)	2,542,195				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	1,176,644				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	1,176,644				50
51	Total liabilities (sum of lines 45 and 50)	3,718,839				51
	CAPITAL ACCOUNTS					
52	General fund balance	10,110,362				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	10,110,362				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	13,829,201				60

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		8,753,518			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,312,738			2
3	Total (sum of line 1 and line 2)		10,066,256			3
4	Additions (credit adjustments) (specify)					4
5	CAPITAL GRANTS	44,087				5
6	UNREALIZED GAIN	19				6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		44,106			10
11	Subtotal (line 3 plus line 10)		10,110,362			11
12	Deductions (debit adjustments) (specify)					12
13	UNREALIZED LOSS					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,110,362			19

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	940,719		940,719	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	940,719		940,719	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	940,719		940,719	17
18	Ancillary services	2,541,518		2,541,518	18
19	Outpatient services		19,795,401	19,795,401	19
20	Rural Health Clinic (RHC)	110,471	1,961,675	2,072,146	20
21	Federally Qualified Health Center (FQHC)				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)	3,592,708	21,757,076	25,349,784	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		14,268,924	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38	INTEREST EXPENSE	-70,590		38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-70,590	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		14,198,334	43

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	25,349,784	1
2	Less contractual allowances and discounts on patients' accounts	10,895,668	2
3	Net patient revenues (line 1 minus line 2)	14,454,116	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	14,198,334	4
5	Net income from service to patients (line 3 minus line 4)	255,782	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	48,308	6
7	Income from investments	11,220	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	12,042	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	1,372	16
17	Revenue from sale of drugs to other than patients	5,636	17
18	Revenue from sale of medical records and abstracts	6,941	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	1,125	21
22	Rental of hosptial space	29,660	22
23	Governmental appropriations	254,656	23
24	Other (OTHER DIETARY REVENUE)	150,854	24
24.01	Other (SALE: MINOR EQUIPMENT/SUPPLIES)		24.01
24.02	Other (FITNESS CENTER)	8,480	24.02
24.03	Other (PHARM 340B RETAIL/CONTRACT REV)	168,057	24.03
24.04	Other (MISC OTHER)	19,871	24.04
24.05	Other (CRNA PASS THROUGH AND OTHER)	20,000	24.05
24.06	Other (MEDICAID EHR)	69,180	24.06
24.07	Other (MEDICARE EHR)	345,158	24.07
25	Total other income (sum of lines 6-24)	1,152,560	25
26	Total (line 5 plus line 25)	1,408,342	26
27	Other expenses (INTEREST EXPENSE)	70,590	27
27.01	Other expenses (LOSS ON DISPOSAL OF ASSET)	25,014	27.01
28	Total other expenses (sum of line 27 and subscripts)	95,604	28
29	Net income (or loss) for the period (line 26 minus line 28)	1,312,738	29

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

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

COMPONENT CCN: 14-3404

WORKSHEET M-1

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	422,265		422,265	-102,698	319,567	-15,210	304,357	1
2	Physician Assistant								2
3	Nurse Practitioner	187,026		187,026		187,026		187,026	3
4	Visiting Nurse								4
5	Other Nurse	165,682		165,682		165,682		165,682	5
6	Clinical Psychologist								6
7	Clinical Social Worker		32,940	32,940		32,940		32,940	7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	200,608		200,608		200,608		200,608	9
10	Subtotal (sum of lines 1 through 9)	975,581	32,940	1,008,521	-102,698	905,823	-15,210	890,613	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement	77,751	11,400	89,151		89,151		89,151	11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement		10,000	10,000		10,000		10,000	13
14	Subtotal (sum of lines 11 through 13)	77,751	21,400	99,151		99,151		99,151	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		56,713	56,713		56,713		56,713	15
16	Transportation (Health Care Staff)		4,623	4,623		4,623		4,623	16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		27,453	27,453	-27,453				18
19	Other Health Care Costs		39,908	39,908	-4,735	35,173		35,173	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		128,697	128,697	-32,188	96,509		96,509	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,053,332	183,037	1,236,369	-134,886	1,101,483	-15,210	1,086,273	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs				-3,231	-3,231		-3,231	26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)				-3,231	-3,231		-3,231	28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs		39,262	39,262	16,192	55,454	-2,876	52,578	30
31	Total Facility Overhead (sum of lines 29 and 30)		39,262	39,262	16,192	55,454	-2,876	52,578	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,053,332	222,299	1,275,631	-121,925	1,153,706	-18,086	1,135,620	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.

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3404** **WORKSHEET M-2**

Check applicable box: **[XX] RHC I** **[ ] FQHC**

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.25	4,578	4,200	5,250		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.65	3,653	2,100	1,365		3
4	Subtotal (sum of lines 1 through 3)	1.90	8,231		6,615	8,231	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker		575			575	7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.90	8,806			8,806	8
9	Physician Services Under Agreements		1,007			1,007	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,086,273	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	-3,231	11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,083,042	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.002983	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	52,578	14
15	Parent provider overhead allocated to facility (see instructions)	1,097,336	15
16	Total overhead (sum of lines 14 and 15)	1,149,914	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,149,914	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,153,344	19
20	Total allowable cost of RHC/FQHC sservices(sum of lines 10 and 19)	2,239,617	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 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3404** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	2,239,617	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	24,515	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,215,102	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	8,806	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	1,007	5
6	Total adjusted visits (line 4 plus line 5)	9,813	6
7	Adjusted cost per visit (line 3 divided by line 6)	225.73	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		78.54		8
9	Rate for program covered visits (see instructions)	225.73	225.73	225.73	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		2,173		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		490,511		11
12	Program covered visits for mental health services (from contractor records)		77		12
13	Program covered cost from mental health services (line 9 x line 12)		17,381		13
14	Limit adjustment for mental health services (see instructions)		17,381		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		507,892		16
16.01	Total program charges (see instructions)(from contractor's records)		442,288		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)		379,318		16.04
16.05	Total program cost (see instructions)		379,318		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		33,745		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		81,709		19
20	Net Medicare cost excluding vaccines (see instructions)		379,318		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,421		21
22	Total reimbursable Program cost (line 20 plus line 21)		383,739		22
23	Allowable bad debts (see instructions)		20,844		23
23.01	Adjusted reimbursable bad debts (see instructions)		15,841		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		20,844		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		399,580		26
26.01	Sequestration adjustment (see instructions)		7,992		26.01
27	Interim payments		369,709		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		21,879		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3404** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	890,613	890,613	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000070	0.001580	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	62	1,407	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	7,584	2,856	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,646	4,263	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,086,273	1,086,273	6
7	Total overhead (from Wkst. M-2, line 16)	1,149,914	1,149,914	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.007039	0.003924	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	8,094	4,512	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	15,740	8,775	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	61	151	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	258.03	58.11	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	7	45	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,806	2,615	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		24,515	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,421	16

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/11/2015 Run Time: 14:33 Version: 2015.03 (08/25/2015)

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

COMPONENT CCN: 14-3404

WORKSHEET M-5

Check applicable box: **[XX] RHC I** **[ ] FQHC**

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				394,735	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter 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	04/22/2015	25,026	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		-25,026	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				369,709	
	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 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	Determine net settlement amount (balance due)		.01		29,871	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				399,580	

8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

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