

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report Date: 11/21/2017 Time: 13:35		
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report		
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status	6. Date Received: _____	10. NPR Date: _____
	(1) As Submitted	7. Contractor No.: _____	11. Contractor's Vendor Code: ____
	(2) Settled without audit	8. <input type="checkbox"/> Initial Report for this Provider CCN	12. <input type="checkbox"/> If line 5, column 1 is 4:
	(3) Settled with audit	9. <input type="checkbox"/> Final Report for this Provider CCN	Enter number of times reopened = 0-9.
	(4) Reopened		
(5) Amended			

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR 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 MARSHALL BROWNING HOSPITAL (14-1331) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2016 and ending 06/30/2017, 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)

G
Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX
		1	2	3	4	5
1	HOSPITAL		-229,168	-546,656		1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF		-246,680			5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC			-112,670		10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL		-475,848	-659,326		200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number 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.

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**WORKSHEET S
PARTS I, II & III**

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 900 NORTH WASHINGTON STREET	P.O. Box:		1
2	City: DUQUOIN	State: IL	ZIP Code: 62832	County: PERRY

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	MARSHALL BROWNING HOSPITAL	14-1331	99914	1	01 / 01 / 2004	N	O	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	MARSHALL BROWNING SWING BED	14-Z331	99914		01 / 01 / 2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	MARSHALL BROWNING PHYSICIAN CLINIC	14-8504	99914		05 / 01 / 2009	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2016	To: 06 / 30 / 2017		20
21	Type of control (see instructions)	2			21

Inpatient PPS Information

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

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

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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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	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.		N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.		N	N	48

		1	2	3	
Teaching Hospitals					
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.		N		56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.		N		57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.		N		58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.		N		59
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 received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.				N		81
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.				N		87

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX	
		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/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

Rural Providers

		1	2			
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105		
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106		
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107		
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	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. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	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:	119,946			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134

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WORKSHEET S-2
PART I

All Providers

140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	1 N	2	140
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If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

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

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	Y	Y	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.	N				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)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)	Y				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)					169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0		171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

		Y/N
Bad Debts		Y/N
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y
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
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N

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

		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	09/26/2017	Y	09/26/2017
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	41,232.00		1,191	149	1,718	1
2	HMO and other (see instructions)									2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						954		1,060	5
6	Hospital Adults & Peds. Swing Bed NF								169	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	41,232.00		2,145	149	2,947	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	41,232.00		2,145	149	2,947	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					3,433		14,853	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							77	238	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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					329	55	615	1
2	HMO and other (see instructions)								2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		156.11			329	55	615	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		15.27						26
27	Total (sum of lines 14-26)		171.38						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	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

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

SNF SERVICES

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

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-8504

WORKSHEET S-8

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

Clinic Address and Identification:

1	Street: 900 N. WASHINGTON	1
2	City: DU QUOIN State: IL ZIP Code: 62832 County: PERRY	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

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

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

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to			
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic	1200	1600	0800	1900	0800	1900	0800	1900	0800	1900	0800	1900	0800	1700	11

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

12	Have you received an approval for an exception to the productivity standard?	1 N	2	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.	1 N		13
14	RHC/FQHC 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

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.426431	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,530,065	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	9,660,521	6
7	Medicaid cost (line 1 times line 6)	4,119,546	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.	589,481	8

State Children's Health Insurance Program (CHIP)(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

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

17	Private grants, donations, or endowment income restricted to fundng charity care		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)	589,481	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)		233,545	233,545	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)		233,545	233,545	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)		233,545	233,545	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,850,051	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	204,053	27
27.0	Medicare allowable bad debts for the entire hospital complex (see instructions)	313,928	27.0
1			1
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	1,536,123	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	764,925	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	998,470	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,587,951	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATION S	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		690,281	690,281	-154,655	535,626	-7,496	528,130	1
1.01	00101	2008 BLDG & FIXT				505,821	505,821		505,821	1.01
1.02	00102	RHC BLDG & FIXT				31,185	31,185		31,185	1.02
2	00200	Cap Rel Costs-Mvble Equip		700,659	700,659	87,398	788,057	-340,709	447,348	2
2.01	00201	2008 MVBLE EQUIP				42,349	42,349		42,349	2.01
2.02	00202	RHC MVBLE EQUIP				1,495	1,495		1,495	2.02
3	00300	Other Cap Rel Costs		36,096	36,096	-36,096			-0	3
4	00400	Employee Benefits Department		2,760,705	2,760,705		2,760,705	-56,408	2,704,297	4
5	00500	Administrative & General	982,547	1,704,589	2,687,136		2,687,136	-481,403	2,205,733	5
6	00600	Maintenance & Repairs	164,666	187,694	352,360		352,360		352,360	6
7	00700	Operation of Plant		259,920	259,920		259,920	-99	259,821	7
8	00800	Laundry & Linen Service	16,119	55,392	71,511		71,511		71,511	8
9	00900	Housekeeping	287,852	41,343	329,195		329,195	-157	329,038	9
10	01000	Dietary	233,783	172,741	406,524	-199,197	207,327	-378	206,949	10
11	01100	Cafeteria				199,197	199,197	-38,098	161,099	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	570,113	10,337	580,450		580,450	-720	579,730	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	217,603	1,049,064	1,266,667		1,266,667	-62,949	1,203,718	15
16	01600	Medical Records & Library	380,346	74,724	455,070		455,070	-687	454,383	16
17	01700	Social Service	301		301		301		301	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,229,818	1,189,429	2,419,247		2,419,247	-1,015,033	1,404,214	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	509,786	116,942	626,728		626,728	-180,589	446,139	50
53	05300	Anesthesiology		240,000	240,000		240,000		240,000	53
54	05400	Radiology-Diagnostic	528,856	535,951	1,064,807		1,064,807	-1,045	1,063,762	54
60	06000	Laboratory	517,926	300,638	818,564		818,564	-5,145	813,419	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	309,565	82,502	392,067		392,067	-1,008	391,059	65
66	06600	Physical Therapy	651,054	58,986	710,040	-133,758	576,282	-1,138	575,144	66
67	06700	Occupational Therapy				98,281	98,281		98,281	67
68	06800	Speech Pathology				35,477	35,477		35,477	68
69	06900	Electrocardiology	34,396	6,220	40,616		40,616		40,616	69
71	07100	Medical Supplies Charged to Patients		817,029	817,029		817,029		817,029	71
73	07300	Drugs Charged to Patients								73
73.01	07301	CARDIAC REHABILITATION	77,538	2,004	79,542		79,542	-1,663	77,879	73.01
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	1,159,750	283,893	1,443,643		1,443,643	-180	1,443,463	88
91	09100	Emergency	586,130	1,157,572	1,743,702		1,743,702	-1,060	1,742,642	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		477,497	477,497	-477,497				113
118		SUBTOTALS (sum of lines 1-117)	8,458,149	13,012,208	21,470,357		21,470,357	-2,195,965	19,274,392	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	194,075	295,747	489,822		489,822	-826	488,996	192
192.0	19202	INDEPENDENT LIVING	87,365	134,846	222,211		222,211		222,211	192.0
2										2
192.0	19203	MEALS ON WHEELS								192.0
3										3
200		TOTAL (sum of lines 118-199)	8,739,589	13,442,801	22,182,390		22,182,390	-2,196,791	19,985,599	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	A	Cafeteria	11	114,554	84,643	1
500	Total reclassifications				114,554	84,643	500
	Code Letter - A						
1	TO RECLASS INTEREST EXP	C	Cap Rel Costs-Mvble Equip	2		102,895	1
2			Cap Rel Costs-Bldg & Fixt	1		188,003	2
3			2008 BLDG & FIXT	1.01		171,671	3
4			2008 MVBLE EQUIP	2.01		14,928	4
500	Total reclassifications					477,497	500
	Code Letter - C						
1	TO RECLASS BOND AMORITZATION	D	2008 BLDG & FIXT	1.01		7,684	1
2			Cap Rel Costs-Mvble Equip	2		1,079	2
3			2008 MVBLE EQUIP	2.01		668	3
500	Total reclassifications					9,431	500
	Code Letter - D						
1	TO RECLASS DEPRECIATION EXPENSE	E	2008 BLDG & FIXT	1.01		316,453	1
2			2008 MVBLE EQUIP	2.01		25,835	2
500	Total reclassifications					342,288	500
	Code Letter - E						
1	TO RECLASS DEPRECIATION EXPENSE	F	RHC BLDG & FIXT	1.02		31,185	1
2			RHC MVBLE EQUIP	2.02		1,495	2
500	Total reclassifications					32,680	500
	Code Letter - F						
1	RECLASS PT COSTS TO OT & SP	G	Occupational Therapy	67	90,116	8,165	1
2			Speech Pathology	68	32,530	2,947	2
500	Total reclassifications				122,646	11,112	500
	Code Letter - G						
	GRAND TOTAL (Increases)				237,200	957,651	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS CAFETERIA COSTS	A	Dietary	10	114,554	84,643		
500	Total reclassifications				114,554	84,643	500	
	Code letter - A							
1	TO RECLASS INTEREST EXP	C	Interest Expense	113		477,497	11	
2							11	
3							11	
4							11	
500	Total reclassifications					477,497	500	
	Code letter - C							
1	TO RECLASS BOND AMORITZATION	D	Cap Rel Costs-Bldg & Fixt	1		9,431	9	
2							9	
3							9	
500	Total reclassifications					9,431	500	
	Code letter - D							
1	TO RECLASS DEPRECIATION EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		316,453	9	
2			Cap Rel Costs-Mvble Equip	2		25,835	9	
500	Total reclassifications					342,288	500	
	Code letter - E							
1	TO RECLASS DEPRECIATION EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		31,185	9	
2			Cap Rel Costs-Mvble Equip	2		1,495	9	
500	Total reclassifications					32,680	500	
	Code letter - F							
1	RECLASS PT COSTS TO OT & SP	G	Physical Therapy	66	122,646	11,112		
2								
500	Total reclassifications				122,646	11,112	500	
	Code letter - G							
	GRAND TOTAL (Decreases)				237,200	957,651		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	3,116					3,116		1
2	Land Improvements	1,202,841					1,202,841		2
3	Buildings and Fixtures	7,412,668					7,412,668		3
4	Building Improvements								4
5	Fixed Equipment	6,706,602	39,550		39,550		6,746,152		5
6	Movable Equipment	5,019,683	414,258		414,258		5,433,941		6
7	HIT-designated Assets	1,970,534				383,562	1,586,972		7
8	Subtotal (sum of lines 1-7)	22,315,444	453,808		453,808	383,562	22,385,690		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	22,315,444	453,808		453,808	383,562	22,385,690		10

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

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	690,281							690,281	1
1.01	2008 BLDG & FIXT									1.01
1.02	RHC BLDG & FIXT									1.02
2	Cap Rel Costs-Mvble Equip	700,659							700,659	2
2.01	2008 MVBLE EQUIP									2.01
2.02	RHC MVBLE EQUIP									2.02
3	Total (sum of lines 1-2)	1,390,940							1,390,940	3

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

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see 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	8,937,606		8,937,606	0.399255			14,411	14,411	1
1.01	2008 BLDG & FIXT	6,209,605		6,209,605	0.277392			10,013	10,013	1.01
1.02	RHC BLDG & FIXT				0.000000					1.02
2	Cap Rel Costs-Mvble Equ	6,669,279		6,669,279	0.297926			10,754	10,754	2
2.01	2008 MVBLE EQUIP	569,200		569,200	0.025427			918	918	2.01
2.02	RHC MVBLE EQUIP				0.000000					2.02
3	Total (sum of lines 1-2)	22,385,690		22,385,690	1.000000			36,096	36,096	3

	Description	SUMMARY OF CAPITAL								
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)		
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	333,212		180,507			14,411		528,130	1
1.01	2008 BLDG & FIXT	324,137		171,671			10,013		505,821	1.01

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RECONCILIATION OF CAPITAL COST CENTERS

**WORKSHEET A-7
PARTS I, II & III**

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		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	
1.02	RHC BLDG & FIXT	31,185						31,185	1.02
2	Cap Rel Costs-Mvble Equip	333,699		102,895			10,754	447,348	2
2.01	2008 MVBLE EQUIP	26,503		14,928			918	42,349	2.01
2.02	RHC MVBLE EQUIP	1,495						1,495	2.02
3	Total (sum of lines 1-2)	1,050,231		470,001			36,096	1,556,328	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)			Cap Rel Costs-Bldg & Fixt	1	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trade, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					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	-178,572			10
11	Sale of scrap, waste, etc. (chapter 23)					11
12	Related organization transactions (chapter 10)	Wkst A-8-1				12
13	Laundry and linen service					13
14	Cafeteria - employees and guests	B	-38,098	Cafeteria	11	14
15	Rental of quarters to employees & others					15
16	Sale of medical and surgical supplies to other than patients					16
17	Sale of drugs to other than patients	B	-61,810	Pharmacy	15	17
18	Sale of medical records and abstracts	B	-687	Medical Records & Library	16	18
19	Nursing school (tuition,fees,books,etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation	A	-340,709	Cap Rel Costs-Mvble Equip	2	9 32
33	MISCELLANEOUS INCOME	B	-61,441	Administrative & General	5	33
34						34
35						35
36	IHA DUES USED FOR LOBBYING	A	-6,461	Administrative & General	5	36
37	MARKETING	A	-78,799	Administrative & General	5	37
38						38
39						39
40	DEPRECIATION	A	-7,496	Cap Rel Costs-Bldg & Fixt	1	11 40
41	DEPRECIATION	A	-11,356	Administrative & General	5	41
42						42
43	DEPRECIATION	A	-99	Operation of Plant	7	43
44	DEPRECIATION	A	-157	Housekeeping	9	44
45	DEPRECIATION	A	-378	Dietary	10	45
45.01	DEPRECIATION	A	-720	Nursing Administration	13	45.01
45.02	DEPRECIATION	A	-1,139	Pharmacy	15	45.02
45.04	DEPRECIATION	A	-2,975	Adults & Pediatrics	30	45.04
45.05	DEPRECIATION	A	-2,017	Operating Room	50	45.05
45.06	DEPRECIATION	A	-1,045	Radiology-Diagnostic	54	45.06
45.07	DEPRECIATION	A	-1,663	CARDIAC REHABILITATION	73.01	45.07
45.08	DEPRECIATION	A	-5,145	Laboratory	60	45.08
45.09	DEPRECIATION	A	-1,008	Respiratory Therapy	65	45.09
45.10	DEPRECIATION	A	-1,138	Physical Therapy	66	45.10
45.11	DEPRECIATION	A	-1,060	Emergency	91	45.11
45.12	DEPRECIATION	A	-180	Rural Health Clinic	88	45.12
45.13	DEPRECIATION	A	-826	Physicians' Private Offices	192	45.13

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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	
45.17	HOSPITALIST PHYSICAN FEES	A	-1,012,058	Adults & Pediatrics	30		45.17
46	EMPLOYED SURGEON EMPLOYEE BENEFITS	A	-56,408	Employee Benefits Department	4		46
47	PROVIDER TAX ASSESSMENT	A	-323,346	Administrative & General	5		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,196,791				50

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

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

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

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier		Total Remun- eration	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	91	Emergency	AGGREGATE	1,121,820		1,121,820					1
2	50	Operating Room	DR. S	178,572	178,572						2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
200		TOTAL		1,300,392	178,572	1,121,820					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 Disallowanc e	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	91	Emergency AGGREGATE								1
2	50	Operating Room DR. S							178,572	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							178,572	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)						1
2	Line 1 multiplied by 15 hours per week						2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					3	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					22.66	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		52.25				9
10	AHSEA (see instructions)		76.61				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)	38.31	38.31				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)					4,003	15
16	Assistants (column 3, line 9 times column 3, line 10)						16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					4,003	17
18	Aides (column 4, line 9 times column 4, line 10)						18
19	Trainees (column 5, line 9 times column 5, line 10)						19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					4,003	20
21	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)					4,003	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)					115	24
25	Assistants (line 4 times column 3, line 11)						25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					115	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					68	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					183	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)					183	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						35

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

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13)						43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.							
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)						44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)						45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)						46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART V - OVERTIME COMPUTATION

		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)		4,003	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		183	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)		4,186	63
64	Total cost of outside supplier services (from provider records)		2,874	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)			65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					53	1
2	Line 1 multiplied by 15 hours per week					795	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					97	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					23.90	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		575.50				9
10	AHSEA (see instructions)		80.83				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)	40.42	40.42				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)					46,518	15
16	Assistants (column 3, line 9 times column 3, line 10)						16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					46,518	17
18	Aides (column 4, line 9 times column 4, line 10)						18
19	Trainees (column 5, line 9 times column 5, line 10)						19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					46,518	20
21	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. 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)					80.83	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)					64,260	22
23	Total salary equivalency (see instructions)					64,260	23

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

Standard Travel Allowance							
24	Therapists (line 3 times column 2, line 11)					3,921	24
25	Assistants (line 4 times column 3, line 11)						25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,921	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,318	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,239	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)					6,239	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						35

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

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13)						43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.							
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)						44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)						45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)						46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART V - OVERTIME COMPUTATION

		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)					64,260	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)					6,239	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)					70,499	63
64	Total cost of outside supplier services (from provider records)					34,530	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)						65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)						1
2	Line 1 multiplied by 15 hours per week						2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					19	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					21.77	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		36.50				9
10	AHSEA (see instructions)		73.61				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)	36.81	36.81				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)					2,687	15
16	Assistants (column 3, line 9 times column 3, line 10)						16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					2,687	17
18	Aides (column 4, line 9 times column 4, line 10)						18
19	Trainees (column 5, line 9 times column 5, line 10)						19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					2,687	20
21	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)					2,687	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)					699	24
25	Assistants (line 4 times column 3, line 11)						25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					699	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					414	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,113	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)					1,113	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						35

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

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13)						43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.							
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)						44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)						45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)						46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART V - OVERTIME COMPUTATION

		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)					2,687	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)					1,113	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)					3,800	63
64	Total cost of outside supplier services (from provider records)					2,190	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 BLDGS + FIXTURES	CAP REL COSTS- BLDG & FIX	CAP MOVABLE EQUIPMENT	CAP MOVABLE EQUIPMENT	
		0	1	1.01	1.02	2	2.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	528,130	528,130					1
1.01	2008 BLDG & FIXT	505,821		505,821				1.01
1.02	RHC BLDG & FIXT	31,185			31,185			1.02
2	Cap Rel Costs-Mvble Equip	447,348				447,348		2
2.01	2008 MVBLE EQUIP	42,349					42,349	2.01
2.02	RHC MVBLE EQUIP	1,495						2.02
4	Employee Benefits Department	2,704,297						4
5	Administrative & General	2,205,733	134,671	13,532		45,980		5
6	Maintenance & Repairs	352,360						6
7	Operation of Plant	259,821	46,187	4,768		812		7
8	Laundry & Linen Service	71,511	18,133			436		8
9	Housekeeping	329,038	10,342			1,630		9
10	Dietary	206,949	21,725			657		10
11	Cafeteria	161,099	6,453			631		11
12	Maintenance of Personnel							12
13	Nursing Administration	579,730	5,267			937		13
14	Central Services & Supply							14
15	Pharmacy	1,203,718		27,766		753	5,942	15
16	Medical Records & Library	454,383	11,383			3,154		16
17	Social Service	301	1,117					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,404,214		284,090		56,857	30,802	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	446,139		129,365		81,883	1,393	50
53	Anesthesiology	240,000						53
54	Radiology-Diagnostic	1,063,762	11,610			185,195		54
60	Laboratory	813,419	3,261	46,300		18,016	4,212	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	391,059	17,657			14,422		65
66	Physical Therapy	575,144	23,655			4,504		66
67	Occupational Therapy	98,281	4,440			779		67
68	Speech Pathology	35,477	972			277		68
69	Electrocardiology	40,616	517					69
71	Medical Supplies Charged to Patients	817,029						71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION	77,879	4,571			11,627		73.01
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	1,443,463			31,185			88
91	Emergency	1,742,642	19,774			14,214		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	19,274,392	341,735	505,821	31,185	442,764	42,349	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,633					190
192	Physicians' Private Offices	488,996	37,175			1,593		192
192.0 2	INDEPENDENT LIVING	222,211	143,587			2,991		192.0 2
192.0 3	MEALS ON WHEELS							192.0 3
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	19,985,599	528,130	505,821	31,185	447,348	42,349	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAP MVBLE EQUI	EMPLOYEE BENEFITS DEPARTMEN T	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	
		2.02	4	4A	5	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP	1,495						2.02
4	Employee Benefits Department		2,704,297					4
5	Administrative & General		310,372	2,710,288	2,710,288			5
6	Maintenance & Repairs		52,015	404,375	63,442	467,817		6
7	Operation of Plant			311,588	48,884		360,472	7
8	Laundry & Linen Service		5,092	95,172	14,931	7,379	21,063	8
9	Housekeeping		90,928	431,938	67,766	4,427	12,013	9
10	Dietary		37,663	266,994	41,888	45,749	25,235	10
11	Cafeteria		36,186	204,369	32,063		7,496	11
12	Maintenance of Personnel							12
13	Nursing Administration		180,090	766,024	120,180		6,119	13
14	Central Services & Supply							14
15	Pharmacy		68,738	1,306,917	205,040	7,379	9,514	15
16	Medical Records & Library		120,146	589,066	92,417	8,117	13,222	16
17	Social Service		95	1,513	237		1,297	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		388,480	2,164,443	339,575	141,671	97,347	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		104,626	763,406	119,769	14,758	44,328	50
53	Anesthesiology			240,000	37,653			53
54	Radiology-Diagnostic		167,058	1,427,625	223,977	64,934	13,487	54
60	Laboratory		163,605	1,048,813	164,546	14,020	19,653	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		97,787	520,925	81,727	4,427	20,510	65
66	Physical Therapy		166,916	770,219	120,838	8,117	33,765	66
67	Occupational Therapy		28,466	131,966	20,704	1,476		67
68	Speech Pathology		10,276	47,002	7,374	738		68
69	Electrocardiology		10,865	51,998	8,158		601	69
71	Medical Supplies Charged to Patients			817,029	128,182			71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION		24,493	118,570	18,602	15,496	5,310	73.01
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	1,495	366,348	1,842,491	289,065	16,233		88
91	Emergency		185,150	1,961,780	307,780	45,011	22,969	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,495	2,615,395	18,994,511	2,554,798	399,932	353,929	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			5,633	884		6,543	190
192	Physicians' Private Offices		61,305	589,069	92,418	60,506		192
192.0	INDEPENDENT LIVING		27,597	396,386	62,188	7,379		192.0
2								2
192.0	MEALS ON WHEELS							192.0
3								3
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,495	2,704,297	19,985,599	2,710,288	467,817	360,472	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	138,545						8
9	Housekeeping		516,144					9
10	Dietary	379	38,771	419,016				10
11	Cafeteria	379			244,307			11
12	Maintenance of Personnel							12
13	Nursing Administration				16,400	908,723		13
14	Central Services & Supply							14
15	Pharmacy		4,201		6,975		1,540,026	15
16	Medical Records & Library		3,961		23,375			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	90,410	319,770	407,293	49,766	572,650		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,311	29,288		10,556	122,217		50
53	Anesthesiology							53
54	Radiology-Diagnostic	14,921	21,366		19,039			54
60	Laboratory		16,685		19,982			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,403	4,921		10,368			65
66	Physical Therapy	3,836	15,604		16,777			66
67	Occupational Therapy	674	2,641		2,828			67
68	Speech Pathology	253	960		943			68
69	Electrocardiology				1,320			69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients						1,540,026	73
73.01	CARDIAC REHABILITATION		2,401		3,205			73.01
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	1,307	22,326		28,842			88
91	Emergency	18,672	22,326		18,662	213,856		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	138,545	505,221	407,293	229,038	908,723	1,540,026	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		10,923		9,991			192
192.0	INDEPENDENT LIVING				5,278			192.0
2								2
192.0	MEALS ON WHEELS			11,723				192.0
3								3
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	138,545	516,144	419,016	244,307	908,723	1,540,026	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
1.01	2008 BLDG & FIXT						1.01
1.02	RHC BLDG & FIXT						1.02
2	Cap Rel Costs-Mvble Equip						2
2.01	2008 MVBLE EQUIP						2.01
2.02	RHC MVBLE EQUIP						2.02
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	730,158					16
17	Social Service		3,047				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	125,050	3,047	4,311,022		4,311,022	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	44,474		1,154,107		1,154,107	50
53	Anesthesiology			277,653		277,653	53
54	Radiology-Diagnostic	38,457		1,823,806		1,823,806	54
60	Laboratory	74,036		1,357,735		1,357,735	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	30,347		675,628		675,628	65
66	Physical Therapy	31,393		1,000,549		1,000,549	66
67	Occupational Therapy	5,494		165,783		165,783	67
68	Speech Pathology	1,831		59,101		59,101	68
69	Electrocardiology			62,077		62,077	69
71	Medical Supplies Charged to Patients			945,211		945,211	71
73	Drugs Charged to Patients			1,540,026		1,540,026	73
73.01	CARDIAC REHABILITATION	27,208		190,792		190,792	73.01
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	198,040		2,398,304		2,398,304	88
91	Emergency	88,948		2,700,004		2,700,004	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	665,278	3,047	18,661,798		18,661,798	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen			13,060		13,060	190
192	Physicians' Private Offices	64,880		827,787		827,787	192
192.0	INDEPENDENT LIVING			471,231		471,231	192.0
2							2
192.0	MEALS ON WHEELS			11,723		11,723	192.0
3							3
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	730,158	3,047	19,985,599		19,985,599	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP BLDGS + FIXTURES	CAP REL COSTS- BLDG & FIX	CAP MOVABLE EQUIPMENT	CAP MOVABLE EQUIPMENT	
		0	1	1.01	1.02	2	2.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General		134,671	13,532		45,980		5
6	Maintenance & Repairs							6
7	Operation of Plant		46,187	4,768		812		7
8	Laundry & Linen Service		18,133			436		8
9	Housekeeping		10,342			1,630		9
10	Dietary		21,725			657		10
11	Cafeteria		6,453			631		11
12	Maintenance of Personnel							12
13	Nursing Administration		5,267			937		13
14	Central Services & Supply							14
15	Pharmacy			27,766		753	5,942	15
16	Medical Records & Library		11,383			3,154		16
17	Social Service		1,117					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			284,090		56,857	30,802	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			129,365		81,883	1,393	50
53	Anesthesiology							53
54	Radiology-Diagnostic		11,610			185,195		54
60	Laboratory		3,261	46,300		18,016	4,212	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		17,657			14,422		65
66	Physical Therapy		23,655			4,504		66
67	Occupational Therapy		4,440			779		67
68	Speech Pathology		972			277		68
69	Electrocardiology		517					69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION		4,571			11,627		73.01
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				31,185			88
91	Emergency		19,774			14,214		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		341,735	505,821	31,185	442,764	42,349	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,633					190
192	Physicians' Private Offices		37,175			1,593		192
192.0	INDEPENDENT LIVING		143,587			2,991		192.0
2								2
192.0	MEALS ON WHEELS							192.0
3								3
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		528,130	505,821	31,185	447,348	42,349	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAP MVBLE EQUI	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		2.02	2A	5	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General		194,183	194,183				5
6	Maintenance & Repairs			4,545	4,545			6
7	Operation of Plant		51,767	3,502		55,269		7
8	Laundry & Linen Service		18,569	1,070	72	3,229	22,940	8
9	Housekeeping		11,972	4,855	43	1,842		9
10	Dietary		22,382	3,001	444	3,869	63	10
11	Cafeteria		7,084	2,297		1,149	63	11
12	Maintenance of Personnel							12
13	Nursing Administration		6,204	8,610		938		13
14	Central Services & Supply							14
15	Pharmacy		34,461	14,690	72	1,459		15
16	Medical Records & Library		14,537	6,621	79	2,027		16
17	Social Service		1,117	17		199		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		371,749	24,338	1,376	14,926	14,969	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		212,641	8,581	143	6,797	879	50
53	Anesthesiology			2,698				53
54	Radiology-Diagnostic		196,805	16,047	631	2,068	2,471	54
60	Laboratory		71,789	11,789	136	3,013		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		32,079	5,855	43	3,145	398	65
66	Physical Therapy		28,159	8,657	79	5,177	635	66
67	Occupational Therapy		5,219	1,483	14		112	67
68	Speech Pathology		1,249	528	7		42	68
69	Electrocardiology		517	584		92		69
71	Medical Supplies Charged to Patients			9,183				71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION		16,198	1,333	151	814		73.01
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	1,495	32,680	20,710	158		216	88
91	Emergency		33,988	22,050	437	3,522	3,092	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,495	1,365,349	183,044	3,885	54,266	22,940	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,633	63		1,003		190
192	Physicians' Private Offices		38,768	6,621	588			192
192.0	INDEPENDENT LIVING		146,578	4,455	72			192.0
2								2
192.0	MEALS ON WHEELS							192.0
3								3
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,495	1,556,328	194,183	4,545	55,269	22,940	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	18,712						9
10	Dietary	1,406	31,165					10
11	Cafeteria			10,593				11
12	Maintenance of Personnel							12
13	Nursing Administration			711	16,463			13
14	Central Services & Supply							14
15	Pharmacy	152		302		51,136		15
16	Medical Records & Library	144		1,014			24,422	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	11,592	30,293	2,157	10,375		4,183	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,062		458	2,214		1,488	50
53	Anesthesiology							53
54	Radiology-Diagnostic	775		826			1,286	54
60	Laboratory	605		866			2,476	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	178		450			1,015	65
66	Physical Therapy	566		727			1,050	66
67	Occupational Therapy	96		123			184	67
68	Speech Pathology	35		41			61	68
69	Electrocardiology			57				69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients					51,136		73
73.01	CARDIAC REHABILITATION	87		139			910	73.01
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	809		1,251			6,624	88
91	Emergency	809		809	3,874		2,975	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	18,316	30,293	9,931	16,463	51,136	22,252	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	396		433			2,170	192
192.0	INDEPENDENT LIVING			229				192.0
2								2
192.0	MEALS ON WHEELS		872					192.0
3								3
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	18,712	31,165	10,593	16,463	51,136	24,422	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
1.01	2008 BLDG & FIXT						1.01
1.02	RHC BLDG & FIXT						1.02
2	Cap Rel Costs-Mvble Equip						2
2.01	2008 MVBLE EQUIP						2.01
2.02	RHC MVBLE EQUIP						2.02
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
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	1,333					17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	1,333	487,291		487,291		30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		234,263		234,263		50
53	Anesthesiology		2,698		2,698		53
54	Radiology-Diagnostic		220,909		220,909		54
60	Laboratory		90,674		90,674		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		43,163		43,163		65
66	Physical Therapy		45,050		45,050		66
67	Occupational Therapy		7,231		7,231		67
68	Speech Pathology		1,963		1,963		68
69	Electrocardiology		1,250		1,250		69
71	Medical Supplies Charged to Patients		9,183		9,183		71
73	Drugs Charged to Patients		51,136		51,136		73
73.01	CARDIAC REHABILITATION		19,632		19,632		73.01
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		62,448		62,448		88
91	Emergency		71,556		71,556		91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	1,333	1,348,447		1,348,447		118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		6,699		6,699		190
192	Physicians' Private Offices		48,976		48,976		192
192.0	INDEPENDENT LIVING		151,334		151,334		192.0
2							2
192.0	MEALS ON WHEELS		872		872		192.0
3							3
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	1,333	1,556,328		1,556,328		202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP BLDGS + FIXTURES SQUARE FEET	CAP REL COSTS-BLDG & FIX SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	CAP MOVABLE EQUIPMENT DOLLAR VALUE	CAP MVBLE EQUI DOLLAR VALUE	
		1	1.01	1.02	2	2.01	2.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	76,601						1
1.01	2008 BLDG & FIXT		21,642					1.01
1.02	RHC BLDG & FIXT			6,100				1.02
2	Cap Rel Costs-Mvble Equip				341,769			2
2.01	2008 MVBLE EQUIP					16,570		2.01
2.02	RHC MVBLE EQUIP						1,611	2.02
4	Employee Benefits Department							4
5	Administrative & General	19,533	579		35,128			5
6	Maintenance & Repairs							6
7	Operation of Plant	6,699	204		620			7
8	Laundry & Linen Service	2,630			333			8
9	Housekeeping	1,500			1,245			9
10	Dietary	3,151			502			10
11	Cafeteria	936			482			11
12	Maintenance of Personnel							12
13	Nursing Administration	764			716			13
14	Central Services & Supply							14
15	Pharmacy		1,188		575	2,325		15
16	Medical Records & Library	1,651			2,410			16
17	Social Service	162						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		12,155		43,438	12,052		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,535		62,558	545		50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,684			141,488			54
60	Laboratory	473	1,981		13,764	1,648		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,561			11,018			65
66	Physical Therapy	3,431			3,441			66
67	Occupational Therapy	644			595			67
68	Speech Pathology	141			212			68
69	Electrocardiology	75						69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION	663			8,883			73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			6,100			1,611	88
91	Emergency	2,868			10,859			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	49,566	21,642	6,100	338,267	16,570	1,611	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	817						190
192	Physicians' Private Offices	5,392			1,217			192
192.0	INDEPENDENT LIVING	20,826			2,285			192.0
2								2
192.0	MEALS ON WHEELS							192.0
3								3
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	528,130	505,821	31,185	447,348	42,349	1,495	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.894558	23.372193	5.112295	1.308919	2.555763	0.927995	203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	EMPLOYEE BENEFITS DEPARTMENT T GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & GENERAL ACCUM COST	MAINTENANCE & REPAIRS TIME SPENT	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		4	5A	5	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department	8,561,016						4
5	Administrative & General	982,547	-2,710,288	17,275,311				5
6	Maintenance & Repairs	164,665		404,375	634			6
7	Operation of Plant			311,588		45,010		7
8	Laundry & Linen Service	16,119		95,172	10	2,630	3,287	8
9	Housekeeping	287,852		431,938	6	1,500		9
10	Dietary	119,229		266,994	62	3,151	9	10
11	Cafeteria	114,554		204,369		936	9	11
12	Maintenance of Personnel							12
13	Nursing Administration	570,113		766,024		764		13
14	Central Services & Supply							14
15	Pharmacy	217,603		1,306,917	10	1,188		15
16	Medical Records & Library	380,346		589,066	11	1,651		16
17	Social Service	301		1,513		162		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,229,818		2,164,443	192	12,155	2,145	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	331,214		763,406	20	5,535	126	50
53	Anesthesiology			240,000				53
54	Radiology-Diagnostic	528,856		1,427,625	88	1,684	354	54
60	Laboratory	517,926		1,048,813	19	2,454		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	309,565		520,925	6	2,561	57	65
66	Physical Therapy	528,408		770,219	11	4,216	91	66
67	Occupational Therapy	90,116		131,966	2		16	67
68	Speech Pathology	32,530		47,002	1		6	68
69	Electrocardiology	34,396		51,998		75		69
71	Medical Supplies Charged to Patients			817,029				71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION	77,538		118,570	21	663		73.01
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	1,159,750		1,842,491	22		31	88
91	Emergency	586,130		1,961,780	61	2,868	443	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	8,279,576	-2,710,288	16,284,223	542	44,193	3,287	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			5,633		817		190
192	Physicians' Private Offices	194,075		589,069	82			192
192.0	INDEPENDENT LIVING	87,365		396,386	10			192.0
2								2
192.0	MEALS ON WHEELS							192.0
3								3
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,704,297		2,710,288	467,817	360,472	138,545	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.315885		0.156888	737.881703	8.008709	42.149376	203
204	Cost to be allocated (Per Wkst. B, Part II)			194,183	4,545	55,269	22,940	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.011240	7.168770	1.227927	6.979008	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		TIME SPENT	MEALS SERVED	MEALS SERVED	HOURS SUPPLIED	COSTED REQUIS.	TIME SPENT	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	4,300						9
10	Dietary	323	13,154					10
11	Cafeteria			1,296				11
12	Maintenance of Personnel							12
13	Nursing Administration			87	87,224			13
14	Central Services & Supply							14
15	Pharmacy	35		37		1,000		15
16	Medical Records & Library	33		124			2,791	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	2,664	12,786	264	54,966		478	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	244		56	11,731		170	50
53	Anesthesiology							53
54	Radiology-Diagnostic	178		101			147	54
60	Laboratory	139		106			283	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41		55			116	65
66	Physical Therapy	130		89			120	66
67	Occupational Therapy	22		15			21	67
68	Speech Pathology	8		5			7	68
69	Electrocardiology			7				69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients					1,000		73
73.01	CARDIAC REHABILITATION	20		17			104	73.01
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	186		153			757	88
91	Emergency	186		99	20,527		340	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	4,209	12,786	1,215	87,224	1,000	2,543	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	91		53			248	192
192.0	INDEPENDENT LIVING			28				192.0
2								2
192.0	MEALS ON WHEELS		368					192.0
3								3
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	516,144	419,016	244,307	908,723	1,540,026	730,158	202
203	Unit Cost Multiplier (Wkst. B, Part I)	120.033488	31.854645	188.508488	10.418268	1,540.026000	261.611609	203
204	Cost to be allocated (Per Wkst. B, Part II)	18,712	31,165	10,593	16,463	51,136	24,422	204
205	Unit Cost Multiplier (Wkst. B, Part II)	4.351628	2.369241	8.173611	0.188744	51.136000	8.750269	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	SOCIAL SERVICE	TIME SPENT						
		17						

GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
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	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	100						30
ANCILLARY SERVICE COST CENTERS								
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION							73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	100						118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.0	INDEPENDENT LIVING							192.0
2								2
192.0	MEALS ON WHEELS							192.0
3								3
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,047						202
203	Unit Cost Multiplier (Wkst. B, Part I)	30.470000						203
204	Cost to be allocated (Per Wkst. B, Part II)	1,333						204
205	Unit Cost Multiplier (Wkst. B, Part II)	13.330000						205

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

		WORKSHEET		
DESCRIPTION		PART	LINE NO.	AMOUNT
1		2	3	4

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,311,022		4,311,022		4,311,022	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,154,107		1,154,107		1,154,107	50
53	Anesthesiology	277,653		277,653		277,653	53
54	Radiology-Diagnostic	1,823,806		1,823,806		1,823,806	54
60	Laboratory	1,357,735		1,357,735		1,357,735	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	675,628		675,628		675,628	65
66	Physical Therapy	1,000,549		1,000,549		1,000,549	66
67	Occupational Therapy	165,783		165,783		165,783	67
68	Speech Pathology	59,101		59,101		59,101	68
69	Electrocardiology	62,077		62,077		62,077	69
71	Medical Supplies Charged to Patients	945,211		945,211		945,211	71
73	Drugs Charged to Patients	1,540,026		1,540,026		1,540,026	73
73.01	CARDIAC REHABILITATION	190,792		190,792		190,792	73.01
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	2,398,304		2,398,304		2,398,304	88
91	Emergency	2,700,004		2,700,004		2,700,004	91
92	Observation Beds (Non-Distinct Part)	338,227		338,227		338,227	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	19,000,025		19,000,025		19,000,025	200
201	Less Observation Beds	338,227		338,227		338,227	201
202	Total (line 200 minus line 201)	18,661,798		18,661,798		18,661,798	202

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	1,339,765		1,339,765				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	28,655	1,093,990	1,122,645	1.028025	1.028025	1.028025	50
53	Anesthesiology	25,704	461,601	487,305	0.569773	0.569773	0.569773	53
54	Radiology-Diagnostic	1,038,599	11,029,957	12,068,556	0.151120	0.151120	0.151120	54
60	Laboratory	1,794,025	8,497,714	10,291,739	0.131925	0.131925	0.131925	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,242,980	807,852	2,050,832	0.329441	0.329441	0.329441	65
66	Physical Therapy	303,169	1,964,213	2,267,382	0.441279	0.441279	0.441279	66
67	Occupational Therapy	113,383	277,858	391,241	0.423736	0.423736	0.423736	67
68	Speech Pathology	15,104	177,427	192,531	0.306969	0.306969	0.306969	68
69	Electrocardiology	307,464	700,373	1,007,837	0.061594	0.061594	0.061594	69
71	Medical Supplies Charged to Patients	868,513	926,032	1,794,545	0.526713	0.526713	0.526713	71
73	Drugs Charged to Patients	1,570,095	1,920,644	3,490,739	0.441175	0.441175	0.441175	73
73.01	CARDIAC REHABILITATION		396,116	396,116	0.481657	0.481657	0.481657	73.01
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		2,170,659	2,170,659				88
91	Emergency	502,233	3,511,883	4,014,116	0.672627	0.672627	0.672627	91
92	Observation Beds (Non-Distinct Part)	12,809	663,924	676,733	0.499794	0.499794	0.499794	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	9,162,498	34,600,243	43,762,741				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	9,162,498	34,600,243	43,762,741				202

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1331

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1.028025		416,086			427,747	50
53	Anesthesiology	0.569773		172,431			98,247	53
54	Radiology-Diagnostic	0.151120		4,269,964			645,277	54
60	Laboratory	0.131925		3,491,654			460,636	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.329441		206,076			67,890	65
66	Physical Therapy	0.441279		773,786			341,456	66
67	Occupational Therapy	0.423736		67,451			28,581	67
68	Speech Pathology	0.306969		18,514			5,683	68
69	Electrocardiology	0.061594		207,394			12,774	69
71	Medical Supplies Charged to Pat	0.526713		919,223			484,167	71
73	Drugs Charged to Patients	0.441175		851,601			375,705	73
73.01	CARDIAC REHABILITATION	0.481657		220,206			106,064	73.01
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
91	Emergency	0.672627		853,105			573,821	91
92	Observation Beds (Non-Distinct	0.499794		336,182			168,022	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)			12,803,673			3,796,070	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)			12,803,673			3,796,070	202

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z331

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
1	2	3	4	5	6	7		
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1.028025						50
53	Anesthesiology	0.569773						53
54	Radiology-Diagnostic	0.151120						54
60	Laboratory	0.131925						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.329441						65
66	Physical Therapy	0.441279						66
67	Occupational Therapy	0.423736						67
68	Speech Pathology	0.306969						68
69	Electrocardiology	0.061594						69
71	Medical Supplies Charged to Pat	0.526713						71
73	Drugs Charged to Patients	0.441175						73
73.01	CARDIAC REHABILITATION	0.481657						73.01
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
91	Emergency	0.672627						91
92	Observation Beds (Non-Distinct	0.499794						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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	Cost Center Description	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)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	487,291	173,091	314,200	1,956	160.63	149	23,934	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)	487,291		314,200	1,956		149	23,934	200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1331

WORKSHEET D
PART II

Check Title v Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
1	2	3	4	5			
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	234,263	1,122,645	0.208671	1,487	310	50
53	Anesthesiology	2,698	487,305	0.005537	714	4	53
54	Radiology-Diagnostic	220,909	12,068,556	0.018305	108,206	1,981	54
60	Laboratory	90,674	10,291,739	0.008810	133,223	1,174	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	43,163	2,050,832	0.021047	103,663	2,182	65
66	Physical Therapy	45,050	2,267,382	0.019869	620	12	66
67	Occupational Therapy	7,231	391,241	0.018482			67
68	Speech Pathology	1,963	192,531	0.010196			68
69	Electrocardiology	1,250	1,007,837	0.001240	6,185	8	69
71	Medical Supplies Charged to Pat	9,183	1,794,545	0.005117	51,664	264	71
73	Drugs Charged to Patients	51,136	3,490,739	0.014649	91,584	1,342	73
73.01	CARDIAC REHABILITATION	19,632	396,116	0.049561			73.01
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	62,448	2,170,659	0.028769			88
91	Emergency	71,556	4,014,116	0.017826	6,363	113	91
92	Observation Beds (Non-Distinct	38,231	676,733	0.056493			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	899,387	42,422,976		503,709	7,390	200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

(A)	Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3 minus col 4.)
		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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	1,956		149	30
31	Intensive Care Unit				31
32	Coronary Care Unit				32
33	Burn Intensive Care Unit				33
34	Surgical Intensive Care Unit				34
35	Other Special Care (specify)				35
40	Subprovider - IPF				40
41	Subprovider - IRF				41
42	Subprovider I				42
43	Nursery				43
44	Skilled Nursing Facility				44
45	Nursing Facility				45
200	Total (lines 30-199)	1,956		149	200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1331

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION							73.01
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
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1331

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1,122,645			1,487				50
53	Anesthesiology	487,305			714				53
54	Radiology-Diagnostic	12,068,556			108,206				54
60	Laboratory	10,291,739			133,223				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,050,832			103,663				65
66	Physical Therapy	2,267,382			620				66
67	Occupational Therapy	391,241							67
68	Speech Pathology	192,531							68
69	Electrocardiology	1,007,837			6,185				69
71	Medical Supplies Charged to Pat	1,794,545			51,664				71
73	Drugs Charged to Patients	3,490,739			91,584				73
73.01	CARDIAC REHABILITATION	396,116							73.01
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	2,170,659							88
91	Emergency	4,014,116			6,363				91
92	Observation Beds (Non-Distinct	676,733							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	42,422,976			503,709				200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1331

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
1	2	3	4	5	6	7		
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	1.028025						50
53	Anesthesiology	0.569773						53
54	Radiology-Diagnostic	0.151120						54
60	Laboratory	0.131925						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.329441						65
66	Physical Therapy	0.441279						66
67	Occupational Therapy	0.423736						67
68	Speech Pathology	0.306969						68
69	Electrocardiology	0.061594						69
71	Medical Supplies Charged to Pat	0.526713						71
73	Drugs Charged to Patients	0.441175						73
73.01	CARDIAC REHABILITATION	0.481657						73.01
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
91	Emergency	0.672627						91
92	Observation Beds (Non-Distinct	0.499794						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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [] PPS
 Applicable [XX] Title XVIII, Part A [] IPF [] SNF [] TEFRA
 Boxes: [] 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)	3,185	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,956	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,718	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	530	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)	530	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	84	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)	85	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,191	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)	598	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)	356	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	147.52	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	4,311,022	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)	12,392	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	12,539	25
26	Total swing-bed cost (see instructions)	1,531,318	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,779,704	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,779,704	37

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,421.12	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,692,554	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)					1,692,554	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,158,372	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,850,926	49

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					849,830	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					505,919	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					1,355,749	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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

**WORKSHEET D-1
PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					238	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,421.12	88
89	Observation bed cost (line 87 x line 88) (see instructions)					338,227	89
		Cost	Routine Cost (from line 21)	col. 1=col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	487,291	4,311,022	0.113034	338,227	38,231	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,185	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,956	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,718	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	530	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)	530	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	84	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)	85	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	149	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	147.52	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	4,311,022	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)	12,392	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	12,539	25
26	Total swing-bed cost (see instructions)	1,531,318	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,779,704	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,779,704	37

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		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		
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,421.12	38	
39	Program general inpatient routine service cost (line 9 x line 38)					211,747	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)					211,747	41	
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)					142,566	48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					354,313	49	

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					23,934	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					7,390	51
52	Total Program excludable cost (sum of lines 50 and 51)					31,324	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					322,989	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1331

**WORKSHEET D-1
PARTS III & IV**

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					238	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1=col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1331

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		992,063		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	1.028025	25,440	26,153	50
53	Anesthesiology	0.569773	14,637	8,340	53
54	Radiology-Diagnostic	0.151120	657,696	99,391	54
60	Laboratory	0.131925	980,366	129,335	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.329441	617,133	203,309	65
66	Physical Therapy	0.441279	72,853	32,148	66
67	Occupational Therapy	0.423736	22,256	9,431	67
68	Speech Pathology	0.306969	6,492	1,993	68
69	Electrocardiology	0.061594	205,666	12,668	69
71	Medical Supplies Charged to Patients	0.526713	521,602	274,735	71
73	Drugs Charged to Patients	0.441175	762,648	336,461	73
73.01	CARDIAC REHABILITATION	0.481657			73.01
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
91	Emergency	0.672627	30,382	20,436	91
92	Observation Beds (Non-Distinct Part)	0.499794	7,948	3,972	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,925,119	1,158,372	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,925,119		202

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z331

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	1.028025			50
53	Anesthesiology	0.569773			53
54	Radiology-Diagnostic	0.151120	27,143	4,102	54
60	Laboratory	0.131925	382,152	50,415	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.329441	244,854	80,665	65
66	Physical Therapy	0.441279	163,355	72,085	66
67	Occupational Therapy	0.423736	69,950	29,640	67
68	Speech Pathology	0.306969	4,550	1,397	68
69	Electrocardiology	0.061594	30,132	1,856	69
71	Medical Supplies Charged to Patients	0.526713	230,237	121,269	71
73	Drugs Charged to Patients	0.441175	411,218	181,419	73
73.01	CARDIAC REHABILITATION	0.481657			73.01
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
91	Emergency	0.672627			91
92	Observation Beds (Non-Distinct Part)	0.499794			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,563,591	542,848	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,563,591		202

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1331

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		205,062		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	1.028025	1,487	1,529	50
53	Anesthesiology	0.569773	714	407	53
54	Radiology-Diagnostic	0.151120	108,206	16,352	54
60	Laboratory	0.131925	133,223	17,575	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.329441	103,663	34,151	65
66	Physical Therapy	0.441279	620	274	66
67	Occupational Therapy	0.423736			67
68	Speech Pathology	0.306969			68
69	Electrocardiology	0.061594	6,185	381	69
71	Medical Supplies Charged to Patients	0.526713	51,664	27,212	71
73	Drugs Charged to Patients	0.441175	91,584	40,405	73
73.01	CARDIAC REHABILITATION	0.481657			73.01
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
91	Emergency	0.672627	6,363	4,280	91
92	Observation Beds (Non-Distinct Part)	0.499794			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		503,709	142,566	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		503,709		202

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1331

WORKSHEET E
PART B

Check applicable box: Hospital IPF IRF SUB (Other) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	3,796,070			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)	3,796,070			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions))				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions))				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	3,834,031			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	43,225			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,882,003			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)	1,908,803			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)	1,908,803			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	1,908,803			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)	278,963			34
35	Adjusted reimbursable bad debts (see instructions)	181,326			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	278,963			36
37	Subtotal (see instructions)	2,090,129			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	2,090,129			40
40.01	Sequestration adjustment (see instructions)	41,803			40.01
41	Interim payments	2,594,982			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-546,656			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1331

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	Total interim payments paid to provider		2,615,977		2,416,982	1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01	01/31/2017	216,000	01/31/2017	178,000	3.01
		.02					3.02
		Program					3.03
		to					3.04
		Provider					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50					3.50
		.51					3.51
		Provider					3.52
		to					3.53
		Program					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		216,000		178,000	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			2,831,977		2,594,982	4
TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01					5.01
		.02					5.02
		Program					5.03
		to					5.04
		Provider					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
		Provider					5.52
		to					5.53
		Program					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01					6.01
		.02		-229,168		-546,656	6.02
7	Total Medicare program liability (see instructions)			2,602,809		2,048,326	7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8	

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

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z331

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		2,003,057		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01	01/31/2017	109,600	3.01
		.02			3.02
		Program			3.03
		to			3.04
		Provider			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
		Provider			3.52
		to			3.53
		Program			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		109,600	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			2,112,657	4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
		Program			5.03
		to			5.04
		Provider			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		Provider			5.52
		to			5.53
		Program			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.02		-246,680	6.02
7	Total Medicare program liability (see instructions)			1,865,977	7
8	Name of Contractor		Contractor Number	NPR Date (Month/Day/Year)	8

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check Hospital CAH
applicable box:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	615	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,191	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,718	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	43,762,741	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	233,545	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

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

1	Inpatient services	2,850,926	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,850,926	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,879,435	6
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
CUSTOMARY CHARGES			
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,879,435	19
20	Deductibles (exclude professional component)	244,267	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,635,168	22
23	Coinsurance	1,967	23
24	Subtotal (line 22 minus line 23)	2,633,201	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	34,965	25
26	Adjusted reimbursable bad debts (see instructions)	22,727	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,965	27
28	Subtotal (sum of lines 24 and 26)	2,655,928	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,655,928	30
30.01	Sequestration adjustment (see instructions)	53,119	30.01
31	Interim payments	2,831,977	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-229,168	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1331

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	Routine service charges			8
9	Ancillary service charges	503,709		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)	503,709		12
CUSTOMARY CHARGES				
13	Amount actually collected from patients liable for payment for services on a cahрге 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)	503,709		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)			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)			29
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	1,315,116				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	5,937,522				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,553,257				6
7	Inventory	647,655				7
8	Prepaid expenses	788,976				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	7,136,012				11
FIXED ASSETS						
12	Land	3,114				12
13	Land improvements	1,202,841				13
14	Accumulated depreciation	-926,921				14
15	Buildings	7,412,669				15
16	Accumulated depreciation	-3,876,431				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	6,844,021				19
20	Accumulated depreciation	-4,518,948				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	5,050,384				23
24	Accumulated depreciation	-3,923,020				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,970,534				27
28	Accumulated depreciation	-1,151,133				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	8,087,110				30
OTHER ASSETS						
31	Investments	7,032,968				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)	7,032,968				35
36	Total assets (sum of lines 11, 30 and 35)	22,256,090				36

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Liabilities and Fund Balances (Omit Cents)		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	259,027				37
38	Salaries, wages and fees payable	1,517,993				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	731,096				40
41	Deferred income	561,104				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,333,000				44
45	Total current liabilities (sum of lines 37 thru 44)	4,402,220				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	9,495,759				47
48	Unsecured loans					48
49	Other long term liabilities	650,712				49
50	Total long term liabilities (sum of lines 46 thru 49)	10,146,471				50
51	Total liabilities (sum of lines 45 and 50)	14,548,691				51
CAPITAL ACCOUNTS						
52	General fund balance	7,707,399				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

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets					
	(Omit Cents)	1	2	3	4	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	7,707,399				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	22,256,090				60

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		7,648,885			1
2	Net income (loss) (from Worksheet G-3, line 29)		58,514			2
3	Total (sum of line 1 and line 2)		7,707,399			3
4	Additions (credit adjustments) (specify)					4
5	RESTRICTED CONTRIBUTIONS					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		7,707,399			11
12	Deductions (debit adjustments) (specify)					12
13	RELEASED FROM RESTRICTION					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		7,707,399			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	RESTRICTED CONTRIBUTIONS					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	RELEASED FROM RESTRICTION					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES					
1	Hospital	1,958,744		1,958,744	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	537,967		537,967	5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	2,496,711		2,496,711	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES					
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	2,496,711		2,496,711	17
18	Ancillary services	7,455,014	28,794,233	36,249,247	18
19	Outpatient services	60,713	4,666,522	4,727,235	19
20	Rural Health Clinic (RHC)		2,195,765	2,195,765	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		1,011,165	1,011,165	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	10,012,438	36,667,685	46,680,123	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		22,182,390	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		22,182,390	43

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	46,680,123	1
2	Less contractual allowances and discounts on patients' accounts	26,197,498	2
3	Net patient revenues (line 1 minus line 2)	20,482,625	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	22,182,390	4
5	Net income from service to patients (line 3 minus line 4)	-1,699,765	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	47,938	6
7	Income from investments	277,379	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	23,802	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	38,098	14
15	Revenue from rental of living quarters	372,350	15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	61,810	17
18	Revenue from sale of medical records and abstracts	687	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	27,238	22
23	Governmental appropriations		23
24	Other (GAIN ON INVESTMENTS - NET)	327,636	24
24.0	Other (OTHER INCOME)	13,620	24.0
1			1
24.0	Other (OTHER GAINS)		24.0
2			2
24.0	Other (GAIN ON SALE OF EQUIPMENT)	103,417	24.0
3			3
24.0	Other (GRANT INCOME)	39,758	24.0
4			4
24.0	Other (EHR REVENUE)	308,061	24.0
5			5
24.0	Other (SPEECH THERAPY CONTRACT)	28,208	24.0
6			6
24.0	Other (340B PROGRAM (NET OF EXPENSES))	88,277	24.0
7			7
25	Total other income (sum of lines 6-24)	1,758,279	25
26	Total (line 5 plus line 25)	58,514	26
27.0	Other expenses (LOSS ON SALE OF EQUIPMENT)		27.0
1			1
29	Net income (or loss) for the period (line 26 minus line 28)	58,514	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-1331

WORKSHEET L

Check Title V Hospital PPS
 Applicable Title XVIII, Part A SUB (Other) Cost Method
 Boxes: Title XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	Capital DRG other than outlier		1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments		2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)		3
4	Number of interns & residents (see instructions)		4
5	Indirect medical education percentage (see instructions)		5
6	Indirect medical education adjustment (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12

PART II - PAYMENT UNDER REASONABLE COST

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		14
15	Current year allowable operating and capital payment (see instructions)		15
16	Current year operating and capital costs (see instructions)		16
17	Current year exception offset amount (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
1.01	2008 BLDG & FIXT						1.01
1.02	RHC BLDG & FIXT						1.02
2	Cap Rel Costs-Mvble Equip						2
2.01	2008 MVBLE EQUIP						2.01
2.02	RHC MVBLE EQUIP						2.02
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
53	Anesthesiology						53
54	Radiology-Diagnostic						54
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
73	Drugs Charged to Patients						73
73.01	CARDIAC REHABILITATION						73.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic						88
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
192.0	INDEPENDENT LIVING						192.0
2							2
192.0	MEALS ON WHEELS						192.0
3							3
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202

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

COMPONENT CCN: 14-8504

WORKSHEET M-1

Check applicable box: RHC I FQHC

		COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	692,096		692,096		692,096		692,096	1
2	Physician Assistant								2
3	Nurse Practitioner	76,301		76,301		76,301		76,301	3
4	Visiting Nurse								4
5	Other Nurse	120,931		120,931		120,931		120,931	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	889,328		889,328		889,328		889,328	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		89,936	89,936		89,936		89,936	11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)		89,936	89,936		89,936		89,936	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		55,165	55,165		55,165		55,165	15
16	Transportation (Health Care Staff)		7,278	7,278		7,278		7,278	16
17	Depreciation-Medical Equipment						-180	-180	17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		62,443	62,443		62,443	-180	62,263	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	889,328	152,379	1,041,707		1,041,707	-180	1,041,527	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.0	Telehealth								25.0
1									1
25.0	Chronic Care Management								25.0
2									2
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		8,672	8,672		8,672		8,672	29
30	Administrative Costs	270,422	122,842	393,264		393,264		393,264	30
31	Total Facility Overhead (sum of lines 29 and 30)	270,422	131,514	401,936		401,936		401,936	31
32	Total facility costs (sum of lines 22, 28 and 31)	1,159,750	283,893	1,443,643		1,443,643	-180	1,443,463	32

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

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-8504

WORKSHEET M-2

Check applicable box: RHC I FQHC

VISITS AND PRODUCTIVITY

		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	1.63	5,105	4,200	6,846		1
2	Physician Assistants	1.54	4,866	2,100	3,234		2
3	Nurse Practitioners	0.60	1,967	2,100	1,260		3
4	Subtotal (sum of lines 1 through 3)	3.77	11,938		11,340	11,938	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	3.77	11,938			11,938	8
9	Physician Services Under Agreements		2,915			2,915	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)					1,041,527	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,041,527	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)					401,936	14
15	Parent provider overhead allocated to facility (see instructions)					954,841	15
16	Total overhead (sum of lines 14 and 15)					1,356,777	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					1,356,777	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,356,777	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,398,304	20

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-8504

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	2,398,304	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	9,020	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,389,284	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	11,938	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	2,915	5
6	Total adjusted visits (line 4 plus line 5)	14,853	6
7	Adjusted cost per visit (line 3 divided by line 6)	160.86	7

		Calculation of Limit (1)		
		Prior to January 1	On or after January 1	(See instr.)
		1	2	3
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			8
9	Rate for program covered visits (see instructions)	160.86	160.86	9
CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	1,717	1,716	10
11	Program cost excluding costs for mental health services (line 9 x line 10)	276,197	276,036	11
12	Program covered visits for mental health services (from contractor records)			12
13	Program covered cost from mental health services (line 9 x line 12)			13
14	Limit adjustment for mental health services (see instructions)			14
15	Graduate Medical Education pass-through cost (see instructions)			15
16	Total Program cost (see instructions)		552,233	16
16.01	Total program charges (see instructions)(from contractor's records)		419,949	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)		416,461	16.04
16.05	Total program cost (see instructions)		416,461	16.05
17	Primary payer payments			17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		31,657	18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		77,658	19
20	Net Medicare cost excluding vaccines (see instructions)		416,461	20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,173	21
22	Total reimbursable Program cost (line 20 plus line 21)		421,634	22
23	Allowable bad debts (see instructions)			23
23.01	Adjusted reimbursable bad debts (see instructions)			23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)			24
25	Other adjustments (specify) (see instructions)			25
26	Net reimbursable amount (see instructions)		421,634	26
26.01	Sequestration adjustment (see instructions)		8,433	26.01
27	Interim payments		525,871	27
28	Tentative settlement (for contractor use only)			28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-112,670	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.

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-8504

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	889,328	889,328	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000009	0.000052	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	8	46	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,944	1,919	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,952	1,965	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,041,527	1,041,527	6
7	Total overhead (from Wkst. M-2, line 16)	1,356,777	1,356,777	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001874	0.001887	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,543	2,560	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	4,495	4,525	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	27	112	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	166.48	40.40	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	17	58	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,830	2,343	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)		9,020	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)		5,173	16

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form CMS-2552-10	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/21/2017 Run Time: 13:35 Version: 2017.10 (11/19/2017)
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC
PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-8504

WORKSHEET M-5

Check applicable box: RHC I FQHC

		Part B		
DESCRIPTION		mm/dd/yyyy	Amount	
		1	2	
1	Total interim payments paid to provider		525,871	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero			2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)			
		.01		3.01
		.02		3.02
		Program .03		3.03
		to .04		3.04
		Provider .05		3.05
		.06		3.06
		.07		3.07
		.08		3.08
		.09		3.09
		.10		3.10
		.50		3.50
		.51		3.51
		Provider .52		3.52
		to .53		3.53
		Program .54		3.54
		.55		3.55
		.56		3.56
		.57		3.57
		.58		3.58
		.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		525,871	
TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)			
		.01		5.01
		.02		5.02
		Program .03		5.03
		to .04		5.04
		Provider .05		5.05
		.06		5.06
		.07		5.07
		.08		5.08
		.09		5.09
		.10		5.10
		.50		5.50
		.51		5.51
		Provider .52		5.52
		to .53		5.53
		Program .54		5.54
		.55		5.55
		.56		5.56
		.57		5.57
		.58		5.58
		.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99		5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01		6.01
		.02	-112,670	6.02
7	Total Medicare program liability (see instructions)		413,201	
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.