Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. [X] ELECTRONICALLY FILED COST REPORT DATE: 09/02/2014 TIME: 09:02 2. [ ] MANUALLY SUBMITTED COST REPORT 3. [ ] IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. [F] MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.	
CONTRACTOR USE ONLY	5. [ ] COST REPORT STATUS 1 -AS SUBMITTED 2 -SETTLED WITHOUT AUDIT 3 -SETTLED WITH AUDIT 4 -REOPENED 5 -AMENDED 6. DATE RECEIVED: _____ 7. CONTRACTOR NO: _____ 8. [ ] INITIAL REPORT FOR THIS PROVIDER CCN 9. [ ] FINAL REPORT FOR THIS PROVIDER CCN	10. NPR DATE: _____ 11. CONTRACTOR'S VENDOR CODE: ___ 12. [ ] IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY DR JOHN WARNER HOSPITAL (14-1303) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 05/01/2013 AND ENDING 04/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 09/02/2014 09:02
upwkpB2ogl3dP1f5JmjFi9DQWpG3Y0
k4CCH0r5AfSvzBEYfr.OjUfJbXS3dp
6iNV0cHVM:0dcXV2

PI Encryption: 09/02/2014 09:02

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

_____
TITLE

_____
DATE

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		224,759	253,898		126,864	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		22,480				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			8,651			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		247,239	262,549		126,864	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 OMD CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Prov-ider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	DR JOHN WARNER HOSPITAL	14-1303	99914	1	03/01/2000	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	SWING BED	14-Z303	99914		03/01/2000	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	RURAL HEALTH CENTER	14-3404	99914		07/03/1995	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 05 / 01 / 2013	To: 04 / 30 / 2014	20
21	Type of control (see instructions)	12		21

	Inpatient PPS Information	1	2	
22	Does this facility qualify for and receive disproportionate share hosptial 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
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	2	N	23

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

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

		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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional paymetn exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N	N		57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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 hosptial trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)					62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)					62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)		N			63

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

	Long Term Care Hospital PPS			
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
	TEFRA Providers			
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

				V	XIX	
Title V and XIX Services				1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.			N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.			N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the appilcable column.				N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.					95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.			N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.					97
Rural Providers				1	2	
105	Does this hospital qualify as a Critical Access Hosptial (CAH)?			Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elinination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			Y		108
		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
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'		N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.			N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.			N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2		118
			Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:		115,989	11,090		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.			N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.			Y		121
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.			N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.					133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.					134

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

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

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
			1	2	3	
155	Hospital	N	N		N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Surpvodier - 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.		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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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 ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
			Y/N	Y/N	
APPROVED EDUCATIONAL ACTIVITIES			1	2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?		N		6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.		N		7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?		N		8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.		N		9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.		N		11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.			N	13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15

		PART A		PART B		
		Y/N	DATE	Y/N	DATE	
PS&R REPORT DATA		1	2	3	4	
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	07/08/2014	Y	07/08/2014	16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N		17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	Y		Y		18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N		19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N		20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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 COSTS			
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 CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	N	33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	35

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

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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
	COMPONENT	WKSTA LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	22	8,030	17,071.00		522	52	717	1
2	HMO AND OTHER (see instructions)						55			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						64		64	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		22	8,030	17,071.00		586	52	781	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)		22	8,030	17,071.00		586	52	781	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44								19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101								22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88							9,244	26
27	TOTAL (sum of lines 14-26)		22							27
28	OBSERVATION BED DAYS							15	219	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

Optimizer Systems, Inc. WinLASH Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		FULL TIME EQUIVALENTS			DISCHARGES				
	COMPONENT	TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					164	16	236	1
2	HMO AND OTHER (see instructions)					18			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)		109.60			164	16	236	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		16.09						26
27	TOTAL (sum of lines 14-26)		125.69						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

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

PART III - HOSPITAL WAGE INDEX SUMMARY

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

Optimizer Systems, Inc. *WinLASH* Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL WAGE RELATED COSTS **WORKSHEET S-3 PART IV**

PART IV - WAGE RELATED COST

PART A - CORE LIST

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

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	Supporting Exhibit for Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4) **EXHIBIT 3**

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

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

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

Optimizer Systems, Inc. *WinLASH* Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPIAL-BASED COMPONENT IDENTIFICATION:

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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

SNF SERVICES

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

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

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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

CHECK APPLICABLE BOX: **[XX] RHC [ ] FQHC**

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:

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

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

FACILITY HOURS OF OPERATIONS(1)

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

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (both type and hours of operation). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400.

		1	2	
12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: CCN NUMBER:			14

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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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)	0.575138	1

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	2,243,416	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	3,976,991	6
7	MEDICAID COST (line 1 times line 6)	2,287,319	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.	43,903	8

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

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

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

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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	43,903	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	703,031	191,359	894,390	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	404,340	110,058	514,398	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	43,276	42,682	85,958	22
23	COST OF CHARITY CARE (line 21 minus line 22)	361,064	67,376	428,440	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,335,122	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	276,894	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	1,058,228	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	608,627	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,037,067	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	1,080,970	31

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	CAP REL COSTS-BLDG & FIXT		342,742	342,742	64,280	407,022	-3,207	403,815	1
2	00200	CAP REL COSTS-MVBLE EQUIP		455,369	455,369	7,372	462,741	-3,312	459,429	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT		1,940,302	1,940,302		1,940,302		1,940,302	4
5	00500	ADMINISTRATIVE & GENERAL	1,083,055	961,100	2,044,155	91,340	2,135,495	-15,633	2,119,862	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	244,049	456,900	700,949	3,817	704,766		704,766	7
8	00800	LAUNDRY & LINEN SERVICE	5,040	86,956	91,996		91,996		91,996	8
9	00900	HOUSEKEEPING	128,867	34,766	163,633		163,633		163,633	9
10	01000	DIETARY	186,462	155,839	342,301	-24,307	317,994	-211,533	106,461	10
11	01100	CAFETERIA				25,557	25,557	-14,105	11,452	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	174,009	10,234	184,243	547	184,790	-4,872	179,918	13
14	01400	CENTRAL SERVICES & SUPPLY	14,323	103,812	118,135	-103,522	14,613		14,613	14
15	01500	PHARMACY	121,759	618,372	740,131	-255,825	484,306	-60,038	424,268	15
16	01600	MEDICAL RECORDS & LIBRARY	135,887	55,105	190,992	7,882	198,874	-4,781	194,093	16
17	01700	SOCIAL SERVICE	40,561	2,189	42,750		42,750		42,750	17
19	01900	NONPHYSICIAN ANESTHETISTS				148,100	148,100		148,100	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 SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	777,877	283,643	1,061,520	-44,752	1,016,768	-122,190	894,578	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	287,772	154,640	442,412		442,412	-89,258	353,154	50
53	05300	ANESTHESIOLOGY		152,478	152,478	-148,100	4,378		4,378	53
54	05400	RADIOLOGY-DIAGNOSTIC	223,750	621,765	845,515		845,515	-781	844,734	54
60	06000	LABORATORY	360,537	596,226	956,763	1,966	958,729	-2,952	955,777	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				2,778	2,778		2,778	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	INTRAVENOUS THERAPY				92,991	92,991		92,991	64
65	06500	RESPIRATORY THERAPY	200,260	74,536	274,796	-23,450	251,346	-700	250,646	65
66	06600	PHYSICAL THERAPY	40,896	413,974	454,870	-16,573	438,297	-8,815	429,482	66
67	06700	OCCUPATIONAL THERAPY								67
68	06800	SPEECH PATHOLOGY								68
69	06900	ELECTROCARDIOLOGY	41,435	26,808	68,243		68,243	-31,662	36,581	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				127,505	127,505	-2,034	125,471	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS		51,095	51,095		51,095		51,095	72
73	07300	DRUGS CHARGED TO PATIENTS				255,825	255,825	-3,501	252,324	73
76	03950	CARDIAC REHAB	46,389	1,914	48,303		48,303		48,303	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	RURAL HEALTH CLINIC	1,086,105	240,330	1,326,435	-163,279	1,163,156	-15,941	1,147,215	88
90	09000	CLINIC				3,698	3,698		3,698	90
90.01	09001	PROVIDER BASED CLINIC								90.01
91	09100	EMERGENCY	689,636	903,384	1,593,020	-23,696	1,569,324		1,569,324	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
113	11300	INTEREST EXPENSE		46,727	46,727	-46,727				113
118		SUBTOTALS (sum of lines 1-117)	5,888,669	8,791,206	14,679,875	-16,573	14,663,302	-595,315	14,067,987	118
		NONREIMBURSABLE COST CENTERS								
192	19200	PHYSICIANS' PRIVATE OFFICES	58,133	3,356	61,489		61,489		61,489	192
192.01	19201	LIFELINE								192.01
192.02	19202	HOME MEDICAL EQUIPMENT								192.02
192.03	19203	COMMUNITY BENEFIT				16,573	16,573		16,573	192.03
192.04	19204	RENTAL PROPERTIES								192.04
200		TOTAL (sum of lines 118-199)	5,946,802	8,794,562	14,741,364		14,741,364	-595,315	14,146,049	200

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COSTS FROM DIET	A	CAFETERIA	11	11,589	13,968	1
500	TOTAL RECLASSIFICATIONS				11,589	13,968	500
	CODE LETTER - A						
1	TO RECLASS DRUGS SOLD TO PATIENTS	B	DRUGS CHARGED TO PATIENTS	73		255,825	1
500	TOTAL RECLASSIFICATIONS					255,825	500
	CODE LETTER - B						
1	TO RECLASS INTEREST EXPENSE	C	CAP REL COSTS-BLDG & FIXT	1		46,727	1
500	TOTAL RECLASSIFICATIONS					46,727	500
	CODE LETTER - C						
1	TO RECLASS SUPPLIES CHARGED TO PTS	D	MEDICAL SUPPLIES CHARGED TO P	71		103,522	1
500	TOTAL RECLASSIFICATIONS					103,522	500
	CODE LETTER - D						
1	TO RECLASS ER PHYSICIAN CONTRACTED	E	ADMINISTRATIVE & GENERAL	5		4,313	1
500	TOTAL RECLASSIFICATIONS					4,313	500
	CODE LETTER - E						
1	TO RECLSS PROPERTY INS EXP	F	OTHER CAP REL COSTS	3		24,925	1
500	TOTAL RECLASSIFICATIONS					24,925	500
	CODE LETTER - F						
1	TO RECLASS RHC ADMIN EXPENSES	G	ADMINISTRATIVE & GENERAL	5		39,571	1
500	TOTAL RECLASSIFICATIONS					39,571	500
	CODE LETTER - G						
1	TO RECLASS OXYGEN SUPPLIES	H	MEDICAL SUPPLIES CHARGED TO P	71		23,983	1
500	TOTAL RECLASSIFICATIONS					23,983	500
	CODE LETTER - H						
1	TO RECLASS NURSING COST	I	INTRAVENOUS THERAPY	64	92,991		1
2			WHOLE BLOOD & PACKED RED BLOO	62	2,778		2
3			CLINIC	90	3,698		3
500	TOTAL RECLASSIFICATIONS				99,467		500
	CODE LETTER - I						
1	TO RECLASS GRANT EXPENSES	J	OPERATION OF PLANT	7		3,817	1
2			DIETARY	10		1,250	2
3			NURSING ADMINISTRATION	13		326	3
4			MEDICAL RECORDS & LIBRARY	16		7,882	4
5			ADULTS & PEDIATRICS	30		9,915	5
6			RESPIRATORY THERAPY	65		533	6
7			EMERGENCY	91		19,843	7
500	TOTAL RECLASSIFICATIONS					43,566	500
	CODE LETTER - J						
1	TO RECLASS RESTRICTED DONATIONS	K	NURSING ADMINISTRATION	13		221	1
2			ADULTS & PEDIATRICS	30		5,044	2
3			EMERGENCY	91		530	3
500	TOTAL RECLASSIFICATIONS					5,795	500
	CODE LETTER - K						
1	TO RECLASS RHC PHYSICIAN ADMIN	L	ADMINISTRATIVE & GENERAL	5	121,742		1
500	TOTAL RECLASSIFICATIONS				121,742		500
	CODE LETTER - L						
1	TO RECLASS ATHLETIC TRAINER COM BEN	M	COMMUNITY BENEFIT	192.03		16,573	1
500	TOTAL RECLASSIFICATIONS					16,573	500
	CODE LETTER - M						
1	TO RECLASS CRNA EXPENSE	N	NONPHYSICIAN ANESTHETISTS	19		148,100	1
500	TOTAL RECLASSIFICATIONS					148,100	500
	CODE LETTER - N						
1	TO RECLASS RHC LAB TESTS	O	LABORATORY	60		1,966	1
500	TOTAL RECLASSIFICATIONS					1,966	500
	CODE LETTER - O						
	GRAND TOTAL (INCREASES)				232,798	728,834	

(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.

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	TO RECLASS CAFETERIA COSTS FROM DIET	A	DIETARY	10	11,589	13,968		1
500	TOTAL RECLASSIFICATIONS				11,589	13,968		500
	CODE LETTER - A							
1	TO RECLASS DRUGS SOLD TO PATIENTS	B	PHARMACY	15		255,825		1
500	TOTAL RECLASSIFICATIONS					255,825		500
	CODE LETTER - B							
1	TO RECLASS INTEREST EXPENSE	C	INTEREST EXPENSE	113		46,727	11	1
500	TOTAL RECLASSIFICATIONS					46,727		500
	CODE LETTER - C							
1	TO RECLASS SUPPLIES CHARGED TO PTS	D	CENTRAL SERVICES & SUPPLY	14		103,522		1
500	TOTAL RECLASSIFICATIONS					103,522		500
	CODE LETTER - D							
1	TO RECLASS ER PHYSICIAN CONTRACTED	E	EMERGENCY	91		4,313		1
500	TOTAL RECLASSIFICATIONS					4,313		500
	CODE LETTER - E							
1	TO RECLSS PROPERTY INS EXP	F	ADMINISTRATIVE & GENERAL	5		24,925	12	1
500	TOTAL RECLASSIFICATIONS					24,925		500
	CODE LETTER - F							
1	TO RECLASS RHC ADMIN EXPENSES	G	RURAL HEALTH CLINIC	88		39,571		1
500	TOTAL RECLASSIFICATIONS					39,571		500
	CODE LETTER - G							
1	TO RECLASS OXYGEN SUPPLIES	H	RESPIRATORY THERAPY	65		23,983		1
500	TOTAL RECLASSIFICATIONS					23,983		500
	CODE LETTER - H							
1	TO RECLASS NURSING COST	I	ADULTS & PEDIATRICS	30	59,711			1
2			EMERGENCY	91	39,756			2
3								3
500	TOTAL RECLASSIFICATIONS				99,467			500
	CODE LETTER - I							
1	TO RECLASS GRANT EXPENSES	J	ADMINISTRATIVE & GENERAL	5		43,566		1
2								2
3								3
4								4
5								5
6								6
7								7
500	TOTAL RECLASSIFICATIONS					43,566		500
	CODE LETTER - J							
1	TO RECLASS RESTRICTED DONATIONS	K	ADMINISTRATIVE & GENERAL	5		5,795		1
2								2
3								3
500	TOTAL RECLASSIFICATIONS					5,795		500
	CODE LETTER - K							
1	TO RECLASS RHC PHYSICIAN ADMIN	L	RURAL HEALTH CLINIC	88	121,742			1
500	TOTAL RECLASSIFICATIONS				121,742			500
	CODE LETTER - L							
1	TO RECLASS ATHLETIC TRAINER COM BEN	M	PHYSICAL THERAPY	66		16,573		1
500	TOTAL RECLASSIFICATIONS					16,573		500
	CODE LETTER - M							
1	TO RECLASS CRNA EXPENSE	N	ANESTHESIOLOGY	53		148,100		1
500	TOTAL RECLASSIFICATIONS					148,100		500
	CODE LETTER - N							
1	TO RECLASS RHC LAB TESTS	O	RURAL HEALTH CLINIC	88		1,966		1
500	TOTAL RECLASSIFICATIONS					1,966		500
	CODE LETTER - O							
	GRAND TOTAL (DECREASES)				232,798	728,834		

(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.

Optimizer Systems, Inc. WinLASH Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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	

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			ACQUISITIONS						
	DESCRIPTION	BEGINNING BALANCES	PURCHASES	DONATION	TOTAL	DISPOSALS AND RETIRE-MENTS	ENDING BALANCE	FULLY DEPREC-IATED ASSETS	
		1	2	3	4	5	6	7	
1	LAND	343,588					343,588		1
2	LAND IMPROVEMENTS								2
3	BUILDINGS AND FIXTURES	10,513,203	13,600		13,600	1,525	10,525,278		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	133,362					133,362		5
6	MOVABLE EQUIPMENT	4,581,061	693,145		693,145	104,987	5,169,219		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	15,571,214	706,745		706,745	106,512	16,171,447		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	15,571,214	706,745		706,745	106,512	16,171,447		10

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

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	342,742						342,742	1
2	CAP REL COSTS-MVBLE EQUIP	455,369						455,369	2
3	TOTAL (sum of lines 1-2)	798,111						798,111	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	DESCRIPTION	GROSS ASSETS	CAPITAL-IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of (cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	10,658,641		10,658,641	0.704251	17,553			17,553	1
2	CAP REL COSTS-MVBLE EQU	4,476,074		4,476,074	0.295749	7,372			7,372	2
3	TOTAL (sum of lines 1-2)	15,134,715		15,134,715	1.000000	24,925			24,925	3

		SUMMARY OF CAPITAL							
	DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of (cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	342,742		43,520	17,553			403,815	1
2	CAP REL COSTS-MVBLE EQUIP	452,057			7,372			459,429	2
3	TOTAL (sum of lines 1-2)	794,799		43,520	24,925			863,244	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.)

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-3,207	CAP REL COSTS-BLDG & FIXT	1	11	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3	INVESTMENT INCOME-OTHER (chapter 2)	B	-6,941	ADMINISTRATIVE & GENERAL	5	11	3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)						4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)						5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)						6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)						7
8	TELEVISION AND RADIO SERVICE (chapter 21)						8
9	PARKING LOT (chapter 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-254,112				10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)	B	-781	RADIOLOGY-DIAGNOSTIC	54		11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-1	53,084				12
13	LAUNDRY AND LINEN SERVICE						13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-14,105	CAFETERIA	11		14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	B	-2,034	MEDICAL SUPPLIES CHARGED TO PATIENTS	71		16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-3,501	DRUGS CHARGED TO PATIENTS	73		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-4,781	MEDICAL RECORDS & LIBRARY	16		18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)						19
20	VENDING MACHINES						20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)						21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS						22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65		23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	OTHER INCOME	B	-2,098	ADMINISTRATIVE & GENERAL	5		33
34	OUTSIDE DIETARY SERVICES	B	-211,533	DIETARY	10		34
35							35
36	FITNESS MGMT	B	-8,213	PHYSICAL THERAPY	66		36
37	OUTSIDE LAB SERVICES	B	-2,952	LABORATORY	60		37
38	OUTSIDE SURGICAL SERVICES	B	-1,200	OPERATING ROOM	50		38
39	OTHER REVENUE - RHC	B	-3,739	RURAL HEALTH CLINIC	88		39
40	RESTING METABOLIC	B	-700	RESPIRATORY THERAPY	65		40
41	LOBBYING EXPENSE	A	-7,444	ADMINISTRATIVE & GENERAL	5		41
42	ADVERTISING EXPENSE	A	-32,984	ADMINISTRATIVE & GENERAL	5		42
43	MARKETING OTHER EXPENSE	A	-12,974	ADMINISTRATIVE & GENERAL	5		43
44	CLINICAL TRAINING CLASSES	A	-4,872	NURSING ADMINISTRATION	13		44
45	NON-ALLOW CONTRIB/HELIPAD	A	-6,276	ADMINISTRATIVE & GENERAL	5		45
46	NON-ALLOW PURCH SVC - CABLE TV	A	-602	PHYSICAL THERAPY	66		46
47	DEPRECIATION ON NON-ALLOW CABLE TV	A	-3,312	CAP REL COSTS-MVBLE EQUIP	2	9	47
48	340B PROGRAM	A	-60,038	PHARMACY	15		48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-595,315				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.

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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 ADJUST-MENTS (col. 4 minus col. 5)*	WKST. A-7 REF.	
	1	2	3	4	5	6	7	
1	5	ADMINISTRATIVE & GENERAL	ADMINISTRATION & GENERAL	53,084		53,084		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			53,084		53,084		5

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

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

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

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

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

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

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

Optimizer Systems, Inc. *WinLASH* Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN-ERATION	PROFESS-IONAL COMPON-ENT	PROVIDER COMPON-ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON-ENT HOURS	UNADJ-USTED RCE LIMIT	5 PERCENT OF UNADJ-USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	60	LABORATORY	1,219		1,219					1
2	69	ELECTROCARDIOLOGY AGGREGATE	31,662	31,662						2
3	91	EMERGENCY CORE	811,130		811,130					3
4	88	RURAL HEALTH CLINIC AGGREGATE	504,923	12,202	492,721					4
5	50	OPERATING ROOM AGGREGATE	88,058	88,058						5
6	30	ADULTS & PEDIATRICS HOSPITALIST	122,190	122,190						6
200		TOTAL	1,559,182	254,112	1,305,070					200

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER-SHIPS & CONTIN-UING EDUCATION	PROVIDER COMPON-ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT-ICE INSURANCE	PROVIDER COMPON-ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW-ANCE	ADJUST-MENT	
	10	11	12	13	14	15	16	17	18	
1	60	LABORATORY								1
2	69	ELECTROCARDIOLOGY AGGREGATE							31,662	2
3	91	EMERGENCY CORE								3
4	88	RURAL HEALTH CLINIC AGGREGATE							12,202	4
5	50	OPERATING ROOM AGGREGATE							88,058	5
6	30	ADULTS & PEDIATRICS HOSPITALIST							122,190	6
200		TOTAL							254,112	200

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					5	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					75	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						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)					6	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.60	7
8	OPTIONAL TRAVEL EXPENSE RATE					0.56	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED			7.00			9
10	AHSEA (see instructions)		71.97	53.98			10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.99	35.99	26.99			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)		15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)	378	16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	378	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)	378	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	54.00	21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)	4,050	22
23	TOTAL SALARY EQUIVALENCY (see instructions)	4,050	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)		24
25	ASSISTANTS (line 4 times column 3, line 11)	162	25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	162	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	34	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)	196	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)	196	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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater 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 OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	4,050	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	196	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)	4,246	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	175	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					12	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					180	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					269	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)					246	4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.60	7
8	OPTIONAL TRAVEL EXPENSE RATE					0.56	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		4,046.25	1,878.50	1,382.97		9
10	AHSEA (see instructions)		75.94	56.96	19.86		10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.97	37.97	28.48			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)	307,272	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)	106,999	16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	414,271	17
18	AIDES (column 4, line 9 times column 4, line 10)	27,466	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)	441,737	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)		22
23	TOTAL SALARY EQUIVALENCY (see instructions)	441,737	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)	10,214	24
25	ASSISTANTS (line 4 times column 3, line 11)	7,006	25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	17,220	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,884	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)	20,104	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)	20,104	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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater 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 OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	441,737	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	20,104	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)	461,841	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	252,082	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS V-VI**

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					6	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					90	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					16	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.60	7
8	OPTIONAL TRAVEL EXPENSE RATE					0.56	8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		44.00				9
10	AHSEA (see instructions)		69.16				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)	34.58	34.58				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)	3,043	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)	3,043	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)	3,043	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.		
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	69.16	21
22	WEIGHTED ALLOWANCE EXCUDING AIDES AND TRAINEES (line 2 times line 21)	6,224	22
23	TOTAL SALARY EQUIVALENCY (see instructions)	6,224	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)	553	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)	553	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	90	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)	643	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)	643	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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

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

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater 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 OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	6,224	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	643	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)	6,867	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	2,877	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	403,815	403,815					1
2	CAP REL COSTS-MVBLE EQUIP	459,429		459,429				2
4	EMPLOYEE BENEFITS DEPARTMENT	1,940,302	2,424	2,757	1,945,483			4
5	ADMINISTRATIVE & GENERAL	2,119,862	43,305	49,270	397,755	2,610,192	2,610,192	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	704,766	78,531	89,343	80,572	953,212	215,681	7
8	LAUNDRY & LINEN SERVICE	91,996	4,783	5,442	1,664	103,885	23,506	8
9	HOUSEKEEPING	163,633	2,371	2,698	42,545	211,247	47,798	9
10	DIETARY	106,461	12,512	14,235	57,734	190,942	43,204	10
11	CAFETERIA	11,452			3,826	15,278	3,457	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	179,918	2,290	2,606	57,448	242,262	54,816	13
14	CENTRAL SERVICES & SUPPLY	14,613	8,158	9,281	4,729	36,781	8,322	14
15	PHARMACY	424,268	6,958	7,916	40,198	479,340	108,459	15
16	MEDICAL RECORDS & LIBRARY	194,093	9,010	10,251	44,863	258,217	58,426	16
17	SOCIAL SERVICE	42,750			13,391	56,141	12,703	17
19	NONPHYSICIAN ANESTHETISTS	148,100				148,100	33,510	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	894,578	49,422	56,229	237,100	1,237,329	279,968	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	353,154	27,831	31,663	95,007	507,655	114,866	50
53	ANESTHESIOLOGY	4,378	1,038	1,181		6,597	1,493	53
54	RADIOLOGY-DIAGNOSTIC	844,734	28,839	32,811	73,870	980,254	221,800	54
60	LABORATORY	955,777	9,706	11,043	101,202	1,077,728	243,855	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,778			917	3,695	836	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	92,991			30,701	123,692	27,988	64
65	RESPIRATORY THERAPY	250,646	1,426	1,623	66,115	319,810	72,363	65
66	PHYSICAL THERAPY	429,482	14,570	16,577	13,502	474,131	107,281	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	36,581	1,426	1,623	13,680	53,310	12,062	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,471				125,471	28,390	71
72	IMPL. DEV. CHARGED TO PATIENTS	51,095				51,095	11,561	72
73	DRUGS CHARGED TO PATIENTS	252,324				252,324	57,093	73
76	CARDIAC REHAB	48,303	1,658	1,887	15,315	67,163	15,197	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,147,215	49,776	56,631	318,381	1,572,003	355,694	88
90	CLINIC	3,698			1,221	4,919	1,113	90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY	1,569,324	21,290	24,222	214,555	1,829,391	413,931	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	14,067,987	377,324	429,289	1,926,291	13,992,164	2,575,373	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	61,489	26,491	30,140	19,192	137,312	31,069	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT	16,573				16,573	3,750	192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	14,146,049	403,815	459,429	1,945,483	14,146,049	2,610,192	202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,168,893						7
8	LAUNDRY & LINEN SERVICE	20,000	147,391					8
9	HOUSEKEEPING	9,915		268,960				9
10	DIETARY	52,316		12,354	298,816			10
11	CAFETERIA					18,735		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	9,576		2,261		791	309,706	13
14	CENTRAL SERVICES & SUPPLY	34,110		8,055		65		14
15	PHARMACY	29,091		6,870		553		15
16	MEDICAL RECORDS & LIBRARY	37,673		8,896		617		16
17	SOCIAL SERVICE					184	6,817	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	206,646	147,391	48,798	298,816	3,263	123,810	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	116,366		27,479		1,307	32,779	50
53	ANESTHESIOLOGY	4,339		1,025				53
54	RADIOLOGY-DIAGNOSTIC	120,584		28,475		1,016		54
60	LABORATORY	40,583		9,583		1,393		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS					13		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY					422		64
65	RESPIRATORY THERAPY	5,964		1,408		910		65
66	PHYSICAL THERAPY	60,922		14,386		186		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	5,964		1,408		188		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB	6,933		1,637		211	7,501	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	208,125		49,148		4,383	35,863	88
90	CLINIC					17		90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY	89,020		21,021		2,952	102,936	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	1,058,127	147,391	242,804	298,816	18,471	309,706	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	110,766		26,156		264		192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,168,893	147,391	268,960	298,816	18,735	309,706	202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	
		14	15	16	17	19	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	87,333						14
15	PHARMACY	551	624,864					15
16	MEDICAL RECORDS & LIBRARY	77		363,906				16
17	SOCIAL SERVICE				75,845			17
19	NONPHYSICIAN ANESTHETISTS					181,610		19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,594		14,230	75,845		2,439,690	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	3,009		9,584			813,045	50
53	ANESTHESIOLOGY	8		5,213		181,610	200,285	53
54	RADIOLOGY-DIAGNOSTIC	8,602		83,531			1,444,262	54
60	LABORATORY	33,804		70,878			1,477,824	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			409			4,953	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY			20,787			172,889	64
65	RESPIRATORY THERAPY	381		7,454			408,290	65
66	PHYSICAL THERAPY	795		35,233			692,934	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	422		7,076			80,430	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,976		5,898			179,735	71
72	IMPL. DEV. CHARGED TO PATIENTS	9,859		1,114			73,629	72
73	DRUGS CHARGED TO PATIENTS		624,864	23,282			957,563	73
76	CARDIAC REHAB	193		1,829			100,664	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,175		28,321			2,254,712	88
90	CLINIC	80		626			6,755	90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY	4,807		48,441			2,512,499	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	87,333	624,864	363,906	75,845	181,610	13,820,159	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES						305,567	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						20,323	192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	87,333	624,864	363,906	75,845	181,610	14,146,049	202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		2,439,690					30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		813,045					50
53	ANESTHESIOLOGY		200,285					53
54	RADIOLOGY-DIAGNOSTIC		1,444,262					54
60	LABORATORY		1,477,824					60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		4,953					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY		172,889					64
65	RESPIRATORY THERAPY		408,290					65
66	PHYSICAL THERAPY		692,934					66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		80,430					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		179,735					71
72	IMPL. DEV. CHARGED TO PATIENTS		73,629					72
73	DRUGS CHARGED TO PATIENTS		957,563					73
76	CARDIAC REHAB		100,664					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		2,254,712					88
90	CLINIC		6,755					90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY		2,512,499					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		13,820,159					118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		305,567					192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT		20,323					192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		14,146,049					202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		2,424	2,757	5,181	5,181		4
5	ADMINISTRATIVE & GENERAL		43,305	49,270	92,575	1,061	93,636	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		78,531	89,343	167,874	215	7,737	7
8	LAUNDRY & LINEN SERVICE		4,783	5,442	10,225	4	843	8
9	HOUSEKEEPING		2,371	2,698	5,069	113	1,715	9
10	DIETARY		12,512	14,235	26,747	154	1,550	10
11	CAFETERIA					10	124	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,290	2,606	4,896	153	1,966	13
14	CENTRAL SERVICES & SUPPLY		8,158	9,281	17,439	13	299	14
15	PHARMACY		6,958	7,916	14,874	107	3,891	15
16	MEDICAL RECORDS & LIBRARY		9,010	10,251	19,261	119	2,096	16
17	SOCIAL SERVICE					36	456	17
19	NONPHYSICIAN ANESTHETISTS						1,202	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		49,422	56,229	105,651	631	10,043	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		27,831	31,663	59,494	253	4,121	50
53	ANESTHESIOLOGY		1,038	1,181	2,219		54	53
54	RADIOLOGY-DIAGNOSTIC		28,839	32,811	61,650	197	7,957	54
60	LABORATORY		9,706	11,043	20,749	269	8,748	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS					2	30	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY					82	1,004	64
65	RESPIRATORY THERAPY		1,426	1,623	3,049	176	2,596	65
66	PHYSICAL THERAPY		14,570	16,577	31,147	36	3,849	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		1,426	1,623	3,049	36	433	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						1,018	71
72	IMPL. DEV. CHARGED TO PATIENTS						415	72
73	DRUGS CHARGED TO PATIENTS						2,048	73
76	CARDIAC REHAB		1,658	1,887	3,545	41	545	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		49,776	56,631	106,407	848	12,760	88
90	CLINIC					3	40	90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY		21,290	24,222	45,512	571	14,846	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		377,324	429,289	806,613	5,130	92,386	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		26,491	30,140	56,631	51	1,115	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						135	192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		403,815	459,429	863,244	5,181	93,636	202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	175,826						7
8	LAUNDRY & LINEN SERVICE	3,008	14,080					8
9	HOUSEKEEPING	1,491		8,388				9
10	DIETARY	7,869		385	36,705			10
11	CAFETERIA					134		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,440		71		6	8,532	13
14	CENTRAL SERVICES & SUPPLY	5,131		251				14
15	PHARMACY	4,376		214		4		15
16	MEDICAL RECORDS & LIBRARY	5,667		277		4		16
17	SOCIAL SERVICE					1	188	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	31,084	14,080	1,522	36,705	23	3,411	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	17,504		857		9	903	50
53	ANESTHESIOLOGY	653		32				53
54	RADIOLOGY-DIAGNOSTIC	18,138		888		7		54
60	LABORATORY	6,104		299		10		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY					3		64
65	RESPIRATORY THERAPY	897		44		6		65
66	PHYSICAL THERAPY	9,164		449		1		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	897		44		1		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB	1,043		51		1	207	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	31,309		1,532		35	988	88
90	CLINIC							90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY	13,390		656		21	2,835	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	159,165	14,080	7,572	36,705	132	8,532	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	16,661		816		2		192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	175,826	14,080	8,388	36,705	134	8,532	202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	
		14	15	16	17	19	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	23,133						14
15	PHARMACY	146	23,612					15
16	MEDICAL RECORDS & LIBRARY	20		27,444				16
17	SOCIAL SERVICE				681			17
19	NONPHYSICIAN ANESTHETISTS					1,202		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	952		1,073	681		205,856	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	797		723			84,661	50
53	ANESTHESIOLOGY	2		393			3,353	53
54	RADIOLOGY-DIAGNOSTIC	2,278		6,299			97,414	54
60	LABORATORY	8,955		5,345			50,479	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			31			63	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY			1,568			2,657	64
65	RESPIRATORY THERAPY	101		562			7,431	65
66	PHYSICAL THERAPY	211		2,657			47,514	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	112		534			5,106	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,291		445			6,754	71
72	IMPL. DEV. CHARGED TO PATIENTS	2,612		84			3,111	72
73	DRUGS CHARGED TO PATIENTS		23,612	1,756			27,416	73
76	CARDIAC REHAB	51		138			5,622	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	311		2,136			156,326	88
90	CLINIC	21		47			111	90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY	1,273		3,653			82,757	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	23,133	23,612	27,444	681		786,631	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES						75,276	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						135	192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS					1,202	1,202	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	23,133	23,612	27,444	681	1,202	863,244	202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		205,856					30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		84,661					50
53	ANESTHESIOLOGY		3,353					53
54	RADIOLOGY-DIAGNOSTIC		97,414					54
60	LABORATORY		50,479					60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		63					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY		2,657					64
65	RESPIRATORY THERAPY		7,431					65
66	PHYSICAL THERAPY		47,514					66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		5,106					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		6,754					71
72	IMPL. DEV. CHARGED TO PATIENTS		3,111					72
73	DRUGS CHARGED TO PATIENTS		27,416					73
76	CARDIAC REHAB		5,622					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		156,326					88
90	CLINIC		111					90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY		82,757					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)		786,631					118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		75,276					192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT		135					192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS		1,202					200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		863,244					202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	69,647						1
2	CAP REL COSTS-MVBLE EQUIP		69,647					2
4	EMPLOYEE BENEFITS DEPARTMENT	418	418	5,892,802				4
5	ADMINISTRATIVE & GENERAL	7,469	7,469	1,204,797	-2,610,192	11,535,857		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	13,544	13,544	244,049		953,212	48,216	7
8	LAUNDRY & LINEN SERVICE	825	825	5,040		103,885	825	8
9	HOUSEKEEPING	409	409	128,867		211,247	409	9
10	DIETARY	2,158	2,158	174,873		190,942	2,158	10
11	CAFETERIA			11,589		15,278		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	395	395	174,009		242,262	395	13
14	CENTRAL SERVICES & SUPPLY	1,407	1,407	14,323		36,781	1,407	14
15	PHARMACY	1,200	1,200	121,759		479,340	1,200	15
16	MEDICAL RECORDS & LIBRARY	1,554	1,554	135,887		258,217	1,554	16
17	SOCIAL SERVICE			40,561		56,141		17
19	NONPHYSICIAN ANESTHETISTS					148,100		19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	8,524	8,524	718,166		1,237,329	8,524	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	4,800	4,800	287,772		507,655	4,800	50
53	ANESTHESIOLOGY	179	179			6,597	179	53
54	RADIOLOGY-DIAGNOSTIC	4,974	4,974	223,750		980,254	4,974	54
60	LABORATORY	1,674	1,674	306,537		1,077,728	1,674	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			2,778		3,695		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY			92,991		123,692		64
65	RESPIRATORY THERAPY	246	246	200,260		319,810	246	65
66	PHYSICAL THERAPY	2,513	2,513	40,896		474,131	2,513	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	246	246	41,435		53,310	246	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					125,471		71
72	IMPL. DEV. CHARGED TO PATIENTS					51,095		72
73	DRUGS CHARGED TO PATIENTS					252,324		73
76	CARDIAC REHAB	286	286	46,389		67,163	286	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	8,585	8,585	964,363		1,572,003	8,585	88
90	CLINIC			3,698		4,919		90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY	3,672	3,672	649,880		1,829,391	3,672	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	65,078	65,078	5,834,669	-2,610,192	11,381,972	43,647	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES	4,569	4,569	58,133		137,312	4,569	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT					16,573		192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	403,815	459,429	1,945,483		2,610,192	1,168,893	202
203	UNIT COST MULT-WS B PT I	5.798024	6.596537	0.330146		0.226268	24.242845	203
204	COST TO BE ALLOC PER B PT II			5,181		93,636	175,826	204
205	UNIT COST MULT-WS B PT II			0.000879		0.008117	3.646632	205

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINIS-TRATION DIRECT NRSG SALAR	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	717						8
9	HOUSEKEEPING		46,982					9
10	DIETARY		2,158	717				10
11	CAFETERIA				4,123,587			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		395		174,009	1,870,464		13
14	CENTRAL SERVICES & SUPPLY		1,407		14,323		452,596	14
15	PHARMACY		1,200		121,759		2,854	15
16	MEDICAL RECORDS & LIBRARY		1,554		135,887		400	16
17	SOCIAL SERVICE				40,561	41,173		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	717	8,524	717	718,166	747,745	18,628	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		4,800		287,772	197,969	15,596	50
53	ANESTHESIOLOGY		179				41	53
54	RADIOLOGY-DIAGNOSTIC		4,974		223,750		44,577	54
60	LABORATORY		1,674		306,537		175,192	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS				2,778			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY				92,991			64
65	RESPIRATORY THERAPY		246		200,260		1,973	65
66	PHYSICAL THERAPY		2,513		40,896		4,119	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		246		41,435		2,188	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						103,522	71
72	IMPL. DEV. CHARGED TO PATIENTS						51,095	72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB		286		46,389	45,301	999	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		8,585		964,363	216,595	6,089	88
90	CLINIC				3,698		413	90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY		3,672		649,880	621,681	24,910	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	717	42,413	717	4,065,454	1,870,464	452,596	118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES		4,569		58,133			192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	147,391	268,960	298,816	18,735	309,706	87,333	202
203	UNIT COST MULT-WS B PT I	205.566248	5.724746	416.758717	0.004543	0.165577	0.192960	203
204	COST TO BE ALLOC PER B PT II	14,080	8,388	36,705	134	8,532	23,133	204
205	UNIT COST MULT-WS B PT II	19.637378	0.178536	51.192469	0.000032	0.004561	0.051112	205

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	NONPHYSIC. ANESTHET. ASSIGNED TIME			
		15	16	17	19			
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	680,093						15
16	MEDICAL RECORDS & LIBRARY		24,029,274					16
17	SOCIAL SERVICE			717				17
19	NONPHYSICIAN ANESTHETISTS				100			19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS		939,676	717				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		632,844					50
53	ANESTHESIOLOGY		344,250		100			53
54	RADIOLOGY-DIAGNOSTIC		5,515,304					54
60	LABORATORY		4,680,289					60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		26,988					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY		1,372,633					64
65	RESPIRATORY THERAPY		492,181					65
66	PHYSICAL THERAPY		2,326,509					66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		467,270					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		389,487					71
72	IMPL. DEV. CHARGED TO PATIENTS		73,529					72
73	DRUGS CHARGED TO PATIENTS	680,093	1,537,390					73
76	CARDIAC REHAB		120,803					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		1,870,083					88
90	CLINIC		41,350					90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY		3,198,688					91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	680,093	24,029,274	717	100			118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	624,864	363,906	75,845	181,610			202
203	UNIT COST MULT-WS B PT I	0.918792	0.015144	105.781032	1,816.100000			203
204	COST TO BE ALLOC PER B PT II	23,612	27,444	681	1,202			204
205	UNIT COST MULT-WS B PT II	0.034719	0.001142	0.949791	12.020000			205

Optimizer Systems, Inc. *WinLASH* Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW-ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	2,439,690		2,439,690			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	813,045		813,045			50
53	ANESTHESIOLOGY	200,285		200,285			53
54	RADIOLOGY-DIAGNOSTIC	1,444,262		1,444,262			54
60	LABORATORY	1,477,824		1,477,824			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,953		4,953			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	172,889		172,889			64
65	RESPIRATORY THERAPY	408,290		408,290			65
66	PHYSICAL THERAPY	692,934		692,934			66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	80,430		80,430			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	179,735		179,735			71
72	IMPL. DEV. CHARGED TO PATIENTS	73,629		73,629			72
73	DRUGS CHARGED TO PATIENTS	957,563		957,563			73
76	CARDIAC REHAB	100,664		100,664			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	2,254,712		2,254,712			88
90	CLINIC	6,755		6,755			90
90.01	PROVIDER BASED CLINIC						90.01
91	EMERGENCY	2,512,499		2,512,499			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	534,292		534,292			92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	14,354,451		14,354,451			200
201	LESS OBSERVATION BEDS	534,292		534,292			201
202	TOTAL (SEE INSTRUCTIONS)	13,820,159		13,820,159			202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)	COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	722,061		722,061				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	80,132	552,712	632,844	1.284748			50
53	ANESTHESIOLOGY	43,543	300,707	344,250	0.581801			53
54	RADIOLOGY-DIAGNOSTIC	423,102	5,092,202	5,515,304	0.261864			54
60	LABORATORY	366,309	4,313,980	4,680,289	0.315755			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		26,988	26,988	0.183526			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY	30,508	1,342,125	1,372,633	0.125954			64
65	RESPIRATORY THERAPY	199,383	292,798	492,181	0.829553			65
66	PHYSICAL THERAPY	31,716	2,294,793	2,326,509	0.297843			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	49,246	418,024	467,270	0.172127			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	159,937	229,550	389,487	0.461466			71
72	IMPL. DEV. CHARGED TO PATIENTS	11,759	61,770	73,529	1.001360			72
73	DRUGS CHARGED TO PATIENTS	428,506	1,108,884	1,537,390	0.622850			73
76	CARDIAC REHAB		120,803	120,803	0.833291			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC		1,870,083	1,870,083				88
90	CLINIC		41,350	41,350	0.163362			90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY	47,983	3,150,705	3,198,688	0.785478			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	3,194	214,421	217,615	2.455217			92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	2,597,379	21,431,895	24,029,274				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)		21,431,895	24,029,274				202

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1.284748		182,137			234,000		50
53	ANESTHESIOLOGY	0.581801		107,910			62,782		53
54	RADIOLOGY-DIAGNOSTIC	0.261864		1,941,249			508,343		54
60	LABORATORY	0.315755		1,922,303			606,977		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183526		18,201			3,340		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.125954		695,131			87,555		64
65	RESPIRATORY THERAPY	0.829553		120,102			99,631		65
66	PHYSICAL THERAPY	0.297843		782,781			233,146		66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.172127		198,495			34,166		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461466		95,306			43,980		71
72	IMPL. DEV. CHARGED TO PATIENTS	1.001360		11,263			11,278		72
73	DRUGS CHARGED TO PATIENTS	0.622850		508,316			316,605		73
76	CARDIAC REHAB	0.833291		65,784			54,817		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
90	CLINIC	0.163362		18,315			2,992		90
90.01	PROVIDER BASED CLINIC								90.01
91	EMERGENCY	0.785478		1,020,412			801,511		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2.455217		126,801			311,324		92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)			7,814,506			3,412,447		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			7,814,506			3,412,447		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1.284748							50
53	ANESTHESIOLOGY	0.581801							53
54	RADIOLOGY-DIAGNOSTIC	0.261864							54
60	LABORATORY	0.315755							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183526							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.125954							64
65	RESPIRATORY THERAPY	0.829553							65
66	PHYSICAL THERAPY	0.297843							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.172127							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461466							71
72	IMPL. DEV. CHARGED TO PATIENTS	1.001360							72
73	DRUGS CHARGED TO PATIENTS	0.622850							73
76	CARDIAC REHAB	0.833291							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
90	CLINIC	0.163362							90
90.01	PROVIDER BASED CLINIC								90.01
91	EMERGENCY	0.785478							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2.455217							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUST-MENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	205,856	13,175	192,681	936	205.86	52	10,705	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)	205,856		192,681	936		52	10,705	200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

(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	84,661	632,844	0.133779			50
53	ANESTHESIOLOGY	3,353	344,250	0.009740			53
54	RADIOLOGY-DIAGNOSTIC	97,414	5,515,304	0.017662			54
60	LABORATORY	50,479	4,680,289	0.010785			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	63	26,988	0.002334			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	INTRAVENOUS THERAPY	2,657	1,372,633	0.001936			64
65	RESPIRATORY THERAPY	7,431	492,181	0.015098			65
66	PHYSICAL THERAPY	47,514	2,326,509	0.020423			66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	5,106	467,270	0.010927			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,754	389,487	0.017341			71
72	IMPL. DEV. CHARGED TO PATIENTS	3,111	73,529	0.042310			72
73	DRUGS CHARGED TO PATIENTS	27,416	1,537,390	0.017833			73
76	CARDIAC REHAB	5,622	120,803	0.046539			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC	156,326	1,870,083	0.083593			88
90	CLINIC	111	41,350	0.002684			90
90.01	PROVIDER BASED CLINIC						90.01
91	EMERGENCY	82,757	3,198,688	0.025872			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	48,165	217,615	0.221331			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	628,940	23,307,213				200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		TOTAL PATIENT DAYS	PER DIEM (col. 5÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	936		52		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)	936		52		200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX [XX] HOSPITAL [ ] IPF [ ] IRF [ ] SUB (OTHER) [ ] SNF [ ] NF [ ] ICF/MR

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTH-ETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (sum of col. 1 through col. 4) 5	TOTAL OUTPAT-IENT COST (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY	181,610				181,610		53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
90	CLINIC							90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	181,610				181,610		200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

CHECK APPLICABLE BOXES: [ ] TITLE V [XX] TITLE XVIII, PART A [XX] TITLE XIX | [XX] HOSPITAL [ ] IPF [ ] IRF | [ ] SUB (OTHER) [ ] SNF [ ] NF | [ ] ICF/MR

		TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPATIENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
(A)	COST CENTER DESCRIPTION	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	632,844							50
53	ANESTHESIOLOGY	344,250	0.527553						53
54	RADIOLOGY-DIAGNOSTIC	5,515,304							54
60	LABORATORY	4,680,289							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	26,988							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	1,372,633							64
65	RESPIRATORY THERAPY	492,181							65
66	PHYSICAL THERAPY	2,326,509							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	467,270							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	389,487							71
72	IMPL. DEV. CHARGED TO PATIENTS	73,529							72
73	DRUGS CHARGED TO PATIENTS	1,537,390							73
76	CARDIAC REHAB	120,803							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC	1,870,083							88
90	CLINIC	41,350							90
90.01	PROVIDER BASED CLINIC								90.01
91	EMERGENCY	3,198,688							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	217,615							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	23,307,213							200

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

			PROGRAM CHARGES			PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1.284748							50
53	ANESTHESIOLOGY	0.581801							53
54	RADIOLOGY-DIAGNOSTIC	0.261864							54
60	LABORATORY	0.315755							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183526							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	INTRAVENOUS THERAPY	0.125954							64
65	RESPIRATORY THERAPY	0.829553							65
66	PHYSICAL THERAPY	0.297843							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.172127							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461466							71
72	IMPL. DEV. CHARGED TO PATIENTS	1.001360							72
73	DRUGS CHARGED TO PATIENTS	0.622850							73
76	CARDIAC REHAB	0.833291							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
90	CLINIC	0.163362							90
90.01	PROVIDER BASED CLINIC								90.01
91	EMERGENCY	0.785478							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2.455217							92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	1,000	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	936	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)	717	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	43	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)	21	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	522	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)	43	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)	21	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	131.13	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,439,690	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)	156,140	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,283,550	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,283,550	37

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					2,439.69	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					1,273,518	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)					1,273,518	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					486,931	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,760,449	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					104,907	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)					51,233	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)					156,140	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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					219	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					2,439.69	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					534,292	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	205,856	2,283,550	0.090147	534,292	48,165	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	1,000	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	936	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)	717	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	43	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)	21	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	52	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16
	SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	131.13	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	2,439,690	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)	156,140	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,283,550	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,283,550	37

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					2,439.69	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					126,864	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)					126,864	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT						43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47
						1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					126,864	49
	PASS-THROUGH COST ADJUSTMENTS						
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					10,705	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					10,705	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					219	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERV-ATION BED COST (from line89)	OBSERV-ATION BED PASS-THROUGH COST col. 3 x col. 4) (see instr-uctions	
		1	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		491,362		30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.284748			50
53	ANESTHESIOLOGY	0.581801			53
54	RADIOLOGY-DIAGNOSTIC	0.261864	243,941	63,879	54
60	LABORATORY	0.315755	234,226	73,958	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183526			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.125954	1,430	180	64
65	RESPIRATORY THERAPY	0.829553	150,307	124,688	65
66	PHYSICAL THERAPY	0.297843	24,961	7,434	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.172127	31,041	5,343	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461466	98,557	45,481	71
72	IMPL. DEV. CHARGED TO PATIENTS	1.001360			72
73	DRUGS CHARGED TO PATIENTS	0.622850	264,576	164,791	73
76	CARDIAC REHAB	0.833291			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
90	CLINIC	0.163362			90
90.01	PROVIDER BASED CLINIC				90.01
91	EMERGENCY	0.785478	1,498	1,177	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2.455217			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		1,050,537	486,931	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,050,537		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.284748			50
53	ANESTHESIOLOGY	0.581801			53
54	RADIOLOGY-DIAGNOSTIC	0.261864	212	56	54
60	LABORATORY	0.315755	4,248	1,341	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183526			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.125954			64
65	RESPIRATORY THERAPY	0.829553	12,605	10,457	65
66	PHYSICAL THERAPY	0.297843	3,923	1,168	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.172127			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461466	9,996	4,613	71
72	IMPL. DEV. CHARGED TO PATIENTS	1.001360			72
73	DRUGS CHARGED TO PATIENTS	0.622850	26,660	16,605	73
76	CARDIAC REHAB	0.833291			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
90	CLINIC	0.163362			90
90.01	PROVIDER BASED CLINIC				90.01
91	EMERGENCY	0.785478			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2.455217			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		57,644	34,240	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		57,644		202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	1.284748			50
53	ANESTHESIOLOGY	0.581801			53
54	RADIOLOGY-DIAGNOSTIC	0.261864			54
60	LABORATORY	0.315755			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.183526			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	INTRAVENOUS THERAPY	0.125954			64
65	RESPIRATORY THERAPY	0.829553			65
66	PHYSICAL THERAPY	0.297843			66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.172127			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.461466			71
72	IMPL. DEV. CHARGED TO PATIENTS	1.001360			72
73	DRUGS CHARGED TO PATIENTS	0.622850			73
76	CARDIAC REHAB	0.833291			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
90	CLINIC	0.163362			90
90.01	PROVIDER BASED CLINIC				90.01
91	EMERGENCY	0.785478			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	2.455217			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	3,412,447			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	3,412,447			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)				17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions)				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions)				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	3,446,571			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	17,987			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	1,187,672			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	2,240,912			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	2,240,912			30
31	PRIMARY PAYER PAYMENTS	26			31
32	SUBTOTAL (line 30 minus line 31)	2,240,886			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)	262,532			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	231,028			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	241,226			36
37	SUBTOTAL (see instructions)	2,471,914			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	2,471,914			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	49,438			40.01
41	INTERIM PAYMENTS	2,168,578			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	253,898			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				1,338,021		2,233,152	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	11/06/2013	19,332	11/06/2013	5,253	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	04/25/2014	52,050			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51			04/25/2014	69,827	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		71,382		-64,574	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,409,403		2,168,578	4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		258,109		303,336	6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,667,512		2,471,914	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.

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				164,481			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO							2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	04/25/2014	424			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04					3.04
		PROVIDER	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50	11/06/2013	1,754			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		-1,330			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)				163,151			4
	TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03					5.03
		TO	.04					5.04
		PROVIDER	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		PROVIDER	.52					5.52
		TO	.53					5.53
		PROGRAM	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		26,268			6.01
	BASED ON THE COST REPORT (1)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				189,419			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.

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK APPLICABLE BOX: **[XX] HOSPITAL [ ] CAH**

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	236	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	522	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	55	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	717	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	24,029,274	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	894,390	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)		8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

CHECK APPLICABLE BOXES: **[ ] TITLE V** **[XX] TITLE XVIII** **[ ] TITLE XIX** **[XX] SWING BED - SNF** **[ ] SWING BED - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	157,701		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (see instructions)			2
3	ANCILLARY SERVICES (from Wkst D-3, col. 3, line 200 for Part A, and sum of Wkst D, Part V, cols. 5 and 7, line 202 for Part B) (for CAH, see instructions)	34,582		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5	PROGRAM DAYS	64		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (sum of lines 1-3 plus lines 6 and 7)	192,283		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	192,283		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	192,283		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	2,864		13
14	80% OF PART B COSTS (line 12 x 80%)			14
15	SUBTOTAL (enter the lesser of line 12 minus line 13, or line 14)	189,419		15
16	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
17	ALLOWABLE BAD DEBTS (see instructions)			17
17.01	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			17.01
18	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			18
19	TOTAL (see instructions)	189,419		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)	3,788		19.01
20	INTERIM PAYMENTS	163,151		20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	22,480		22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3 PART V**

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

1	INPATIENT SERVICES	1,760,449	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	1,760,449	4
5	PRIMARY PAYER PAYMENTS	1,547	5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	1,776,506	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (not to exceed 1.000000)	0.000000	13
14	TOTAL CUSTOMARY CHARGES (see instructions)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 14 exceeds line 6) (see instructions)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 6 exceeds line 14) (see instructions)		16
17	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	1,776,506	19
20	DEDUCTIBLES (exclude professional component)	132,609	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	1,643,897	22
23	COINSURANCE	611	23
24	SUBTOTAL (line 22 minus line 23)	1,643,286	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	27,529	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	24,226	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	23,143	27
28	SUBTOTAL (sum of lines 24 and 26)	1,667,512	28
29	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		29
30	SUBTOTAL (line 28 plus or minus line 29)	1,667,512	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	33,350	30.01
31	INTERIM PAYMENTS	1,409,403	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	224,759	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	126,864		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	126,864		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	126,864		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)			15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)	126,864		21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	126,864		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)	126,864		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)	126,864		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	126,864		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	126,864		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	126,864		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

BALANCE SHEET **WORKSHEET G**

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

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1,554,734				1
2	TEMPORARY INVESTMENTS	916,256				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	4,747,157				4
5	OTHER RECEIVABLES	236,000				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-2,257,180				6
7	INVENTORY	295,197				7
8	PREPAID EXPENSES	219,315				8
9	OTHER CURRENT ASSETS	78,127				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	5,789,606				11
	FIXED ASSETS					
12	LAND	343,587				12
13	LAND IMPROVEMENTS					13
14	ACCUMULATED DEPRECIATION					14
15	BUILDINGS	10,525,279				15
16	ACCUMULATED DEPRECIATION	-7,074,355				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	133,362				19
20	ACCUMULATED DEPRECIATION	-66,327				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	4,476,074				23
24	ACCUMULATED DEPRECIATION	-4,119,688				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE	693,145				29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	4,911,077				30
	OTHER ASSETS					
31	INVESTMENTS	1,102				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	304,837				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	305,939				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	11,006,622				36

	LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	556,210				37
38	SALARIES, WAGES & FEES PAYABLE	633,827				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	279,178				40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	30,706				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	1,499,921				45
	LONG TERM LIABILITIES					
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	753,183				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	753,183				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	2,253,104				51
	CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	8,753,518				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	8,753,518				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	11,006,622				60

Optimizer Systems, Inc. WinLASH Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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		7,747,007			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		1,007,433			2
3	TOTAL (sun of line 1 and line 2)		8,754,440			3
4	ADDITIONS (credit adjustments)					4
5	CAPITAL GRANTS					5
6	UNREALIZED GAIN	-922				6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		-922			10
11	SUBTOTAL (line 3 plus line 10)		8,753,518			11
12	DEDUCTIONS (debit adjustments)					12
13	UNREALIZED LOSS					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		8,753,518			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 (sun of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	CAPITAL GRANTS					5
6	UNREALIZED GAIN					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	UNREALIZED LOSS					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	803,886		803,886	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	803,886		803,886	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)	803,886		803,886	17
18	ANCILLARY SERVICES	1,910,617		1,910,617	18
19	OUTPATIENT SERVICES		19,738,311	19,738,311	19
20	RHC	113,681	1,870,083	1,983,764	20
21	FQHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	2,828,184	21,608,394	24,436,578	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		14,741,364	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38	INTEREST EXPENSE	-46,727		38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)		-46,727	42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		14,694,637	43

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	24,436,578	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	9,616,059	2
3	NET PATIENT REVENUES (line 1 minus line 2)	14,820,519	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	14,694,637	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	125,882	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	53,114	6
7	INCOME FROM INVESTMENTS	10,281	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	14,105	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS	2,034	16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	3,501	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	8,519	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	1,248	21
22	RENTAL OF HOSPITAL SPACE	27,676	22
23	GOVERNMENTAL APPROPRIATIONS	254,460	23
24	OTHER (OTHER DIETARY REVENUE)	211,533	24
24.01	OTHER (SALE: MINOR EQUIPMENT/SUPPLIES)		24.01
24.02	OTHER (FITNESS CENTER)	8,213	24.02
24.03	OTHER (PHARM 340B RETAIL/CONTRACT REV)	171,908	24.03
24.04	OTHER (MISC OTHER)	19,329	24.04
24.05	OTHER (GAIN ON DISPOSAL OF ASSET)		24.05
24.06	OTHER (CRNA PASS THROUGH AND OTHER)	56,001	24.06
24.07	OTHER (MEDICAID EHR)	86,475	24.07
25	TOTAL OTHER INCOME (sum of lines 6-24)	928,397	25
26	TOTAL (line 5 plus line 25)	1,054,279	26
27	OTHER EXPENSES (INTEREST EXPENSE)	46,727	27
27.01	OTHER EXPENSES (LOSS ON DISPOSAL OF ASSET)	119	27.01
28	TOTAL OTHER EXPENSES (sum of line 27 and subscripts)	46,846	28
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	1,007,433	29

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5	ADMINISTRATIVE & GENERAL							5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
90	CLINIC							90
90.01	PROVIDER BASED CLINIC							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202

Optimizer Systems, Inc. WinLASH Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

COMPONENT CCN: 14-3404

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	407,521		407,521	-121,742	285,779	-12,202	273,577	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	174,972		174,972		174,972		174,972	3
4	VISITING NURSE								4
5	OTHER NURSE	218,494		218,494		218,494		218,494	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER		34,230	34,230		34,230		34,230	7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS	198,281		198,281		198,281		198,281	9
10	SUBTOTAL (sum of lines 1-9)	999,268	34,230	1,033,498	-121,742	911,756	-12,202	899,554	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT	86,837	10,566	97,403		97,403		97,403	11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT		10,000	10,000		10,000		10,000	13
14	SUBTOTAL (sum of lines 11-13)	86,837	20,566	107,403		107,403		107,403	14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		67,400	67,400		67,400		67,400	15
16	TRANSPORTATION (Health Care Staff)		5,477	5,477		5,477		5,477	16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSIONAL LIABILITY INSURANCE		34,925	34,925	-34,925				18
19	OTHER HEALTH CARE COSTS		40,903	40,903	-4,646	36,257		36,257	19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		148,705	148,705	-39,571	109,134		109,134	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	1,086,105	203,501	1,289,606	-161,313	1,128,293	-12,202	1,116,091	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS				-1,966	-1,966		-1,966	26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)				-1,966	-1,966		-1,966	28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS		36,829	36,829		36,829	-3,739	33,090	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)		36,829	36,829		36,829	-3,739	33,090	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	1,086,105	240,330	1,326,435	-163,279	1,163,156	-15,941	1,147,215	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.

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	1.39	4,636	4,200	5,838		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	0.99	3,215	2,100	2,079		3
4	SUBTOTAL (sum of lines 1-3)	2.38	7,851		7,917	7,917	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER		555			555	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 4-7)	2.38	8,406			8,472	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		838			838	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)	1,116,091	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)	-1,966	11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)	1,114,125	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)	1.001765	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)	33,090	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)	1,107,497	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)	1,140,587	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)		17
18	SUBTRACT LINE 17 FROM LINE 16	1,140,587	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)	1,142,600	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)	2,258,691	20

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

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	2,258,691	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	10,133	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	2,248,558	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	8,472	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)	838	5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	9,310	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	241.52	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		78.54		8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	241.52	241.52	241.52	9
	CALCULATION OF SETTLEMENT				
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		2,271		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		548,492		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)		73		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)		17,631		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)		17,631		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		566,123		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		466,526		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)		421,259		16.04
16.05	TOTAL PROGRAM COST (see instructions)		421,259		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		39,549		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		86,806		19
20	NET MEDICARE COST EXCUDING VACCINES (see instructions)		421,259		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		3,582		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		424,841		22
23	ALLOWABLE BAD DEBTS (see instructions)		24,591		23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		21,995		24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		446,481		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		8,930		26.01
27	INTERIM PAYMENTS		428,900		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		8,651		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

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

Optimizer Systems, Inc. WinLASH Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	899,554	899,554	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000080	0.002010	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	72	1,808	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	575	2,556	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	647	4,364	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	1,116,091	1,116,091	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	1,140,587	1,140,587	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.000580	0.003910	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	662	4,460	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	1,309	8,824	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	9	238	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	145.44	37.08	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	5	77	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	727	2,855	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		10,133	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		3,582	16

Optimizer Systems, Inc. **WinLASH** Micro System

DR JOHN WARNER HOSPITAL Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/02/2014 Run Time: 09:02 Version: 2014.03

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

COMPONENT CCN: 14-3404

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				380,858	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. If NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01	04/25/2014	32,563	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02	11/06/2013	15,479	3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM	.03			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO	.04			3.04
		PROVIDER	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		48,042	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)				428,900	
	TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01			5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02			5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03			5.03
		TO	.04			5.04
		PROVIDER	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		PROVIDER	.52			5.52
		TO	.53			5.53
		PROGRAM	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		.01		17,581	6.01
	BASED ON THE COST REPORT (1)		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				446,481	

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.