MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/24/2015 Time: 10:46 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(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		41,493	-140,166	1		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		129,169				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			78,670			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		170,662	-61,496	1		200

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

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control
number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions,
search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions
for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence

not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions
or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	MARSHALL BROWNING HOSPITAL	14-1331	99914	1	01 / 01 / 2004	N	O	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	MARSHALL BROWNING SWING BED	14-Z331	99914		01 / 01 / 2004	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	MARSHALL BROWNING PHYSICIAN CLINIC	14-8504	99914		05 / 01 / 2009	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 07 / 01 / 2014	To: 06 / 30 / 2015	20
21	Type of control (see instructions)	2		21

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

Prospective Payment System (PPS)-Capital		V	XVIII	XIX	
		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital reseived HRSA PCRE funding (see instructions)					62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)					62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

Inpatient Psychiatric Facilty PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

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

TEFRA Providers				
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

Rural Providers		1	2	
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	Y		108

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

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	223,152			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		N		121

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

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)	N		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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1		168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10 / 01 / 2014	09 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	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	09/22/2015	Y	09/22/2015	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE **WORKSHEET S-2 PART II**

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

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

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

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

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35

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

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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	29,976.00		810	148	1,249	1
2	HMO and other (see instructions)						41			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						899		980	5
6	Hospital Adults & Peds. Swing Bed NF								264	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	29,976.00		1,709	148	2,493	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	29,976.00		1,709	148	2,493	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					2,229		5,748	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							33	137	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					214	49	475	1
2	HMO and other (see instructions)					13			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)		146.85			214	49	475	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		9.29						26
27	Total (sum of lines 14-26)		156.14						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA **WORKSHEET S-5**

RENAL DIALYSIS STATISTICS

		Outpatient		Training		Home		
	DESCRIPTION	Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list		11
12	Number of patients transplanted during the cost reporting period		12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider		13
14	Epoetin amount from Worksheet A for home dialysis program		14
15	Number of EPO units furnished relating to the renal dialysis department		15
16	Number of EPO units furnished relating to the home dialysis department		16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider		17
18	ARANESP amount from Worksheet A for home dialysis program		18
19	Number of ARANESP units furnished relating to the renal dialysis department		19
20	Number of ARANESP units furnished relating to the home dialysis department		20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable mrthod(s))

21	MCP	INITIAL METHOD	

	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

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

SNF SERVICES

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

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

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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA **COMPONENT CCN: 14-8504** **WORKSHEET S-8**

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

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0800	1630	0800	1630	0800	1630	0800	1630	0800	1630			11

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

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	Provider name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.454290	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,083,675	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	7,236,505	6
7	Medicaid cost (line 1 times line 6)	3,287,472	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.	203,797	8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	203,797	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		180,616	180,616	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)		82,052	82,052	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)		82,052	82,052	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)	1,894,775	26
27	Medicare bad debts for the entire hospital complex (see instructions)	212,772	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,682,003	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	764,117	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	846,169	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,049,966	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		712,973	712,973	-216,338	496,635	-10,118	486,517	1
1.01	00101	2008 BLDG & FIXT				490,902	490,902		490,902	1.01
1.02	00102	RHC BLDG & FIXT				31,953	31,953		31,953	1.02
2	00200	Cap Rel Costs-Mvble Equip		624,037	624,037	66,411	690,448	-356,948	333,500	2
2.01	00201	2008 MVBLE EQUIP				55,000	55,000		55,000	2.01
2.02	00202	RHC MVBLE EQUIP				1,579	1,579		1,579	2.02
3	00300	Other Cap Rel Costs		33,626	33,626	-33,626			-0-	3
4	00400	Employee Benefits Department		1,981,010	1,981,010		1,981,010		1,981,010	4
5	00500	Administrative & General	927,342	1,297,032	2,224,374		2,224,374	-417,285	1,807,089	5
6	00600	Maintenance & Repairs	181,046	128,520	309,566		309,566		309,566	6
7	00700	Operation of Plant		217,587	217,587		217,587	-470	217,117	7
8	00800	Laundry & Linen Service	13,628	38,862	52,490		52,490		52,490	8
9	00900	Housekeeping	222,805	34,428	257,233		257,233	-157	257,076	9
10	01000	Dietary	206,371	134,623	340,994	-173,907	167,087	-480	166,607	10
11	01100	Cafeteria				173,907	173,907	-40,664	133,243	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	502,997	15,864	518,861		518,861	-1,316	517,545	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	223,297	675,672	898,969		898,969	-58,190	840,779	15
16	01600	Medical Records & Library	195,226	29,827	225,053		225,053	-1,086	223,967	16
17	01700	Social Service	29,898	56	29,954		29,954	-82	29,872	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	946,790	484,630	1,431,420		1,431,420	-390,624	1,040,796	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	223,873	77,366	301,239		301,239	-2,545	298,694	50
53	05300	Anesthesiology		240,000	240,000		240,000		240,000	53
54	05400	Radiology-Diagnostic	435,599	495,511	931,110		931,110	5,069	936,179	54
60	06000	Laboratory	459,353	270,260	729,613		729,613	1,494	731,107	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	213,430	58,089	271,519		271,519	4,551	276,070	65
66	06600	Physical Therapy	553,520	42,879	596,399	-97,628	498,771	2,672	501,443	66
67	06700	Occupational Therapy				84,417	84,417		84,417	67
68	06800	Speech Pathology				13,211	13,211		13,211	68
69	06900	Electrocardiology	26,293	6,089	32,382		32,382		32,382	69
71	07100	Medical Supplies Charged to Patients		542,792	542,792		542,792		542,792	71
73	07300	Drugs Charged to Patients								73
73.01	07301	CARDIAC REHABILITATION	46,640	1,961	48,601		48,601	-2,007	46,594	73.01
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	645,624	76,074	721,698		721,698	-281	721,417	88
91	09100	Emergency	519,543	1,038,887	1,558,430		1,558,430	-635,983	922,447	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		627,174	627,174	-395,881	231,293	-231,293		113
118		SUBTOTALS (sum of lines 1-117)	6,573,275	9,885,829	16,459,104		16,459,104	-2,135,743	14,323,361	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	477,308	249,481	726,789		726,789	-184,876	541,913	192
192.02	19202	INDEPENDENT LIVING	68,713	117,081	185,794		185,794	-30	185,764	192.02
192.03	19203	MEALS ON WHEELS								192.03
200		TOTAL (sum of lines 118-199)	7,119,296	10,252,391	17,371,687		17,371,687	-2,320,649	15,051,038	200

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COSTS	A	Cafeteria	11	105,249	68,658	1
500	Total reclassifications				105,249	68,658	500
	Code Letter - A						
1	TO RECLASS INTEREST EXP	C	Cap Rel Costs-Mvble Equip	2		97,176	1
2			Cap Rel Costs-Bldg & Fixt	1		149,912	2
3			2008 BLDG & FIXT	1.01		136,890	3
4			2008 MVBLE EQUIP	2.01		11,903	4
500	Total reclassifications					395,881	500
	Code Letter - C						
1	TO RECLASS BOND AMORITZATION	D	2008 BLDG & FIXT	1.01		13,883	1
2			Cap Rel Costs-Mvble Equip	2		1,950	2
3			2008 MVBLE EQUIP	2.01		1,207	3
500	Total reclassifications					17,040	500
	Code Letter - D						
1	TO RECLASS DEPRECIATION EXPENSE	E	2008 BLDG & FIXT	1.01		330,766	1
2			2008 MVBLE EQUIP	2.01		41,032	2
500	Total reclassifications					371,798	500
	Code Letter - E						
1	TO RECLASS DEPRECIATION EXPENSE	F	RHC BLDG & FIXT	1.02		31,953	1
2			RHC MVBLE EQUIP	2.02		1,579	2
500	Total reclassifications					33,532	500
	Code Letter - F						
1	RECLASS PT COSTS TO OT & SP	G	Occupational Therapy	67	78,348	6,069	1
2			Speech Pathology	68	12,261	950	2
500	Total reclassifications				90,609	7,019	500
	Code Letter - G						
	GRAND TOTAL (Increases)				195,858	893,928	

(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.

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS CAFETERIA COSTS	A	Dietary	10	105,249	68,658		1
500	Total reclassifications				105,249	68,658		500
	Code letter - A							
1	TO RECLASS INTEREST EXP	C	Interest Expense	113		395,881	11	1
2							11	2
3							11	3
4							11	4
500	Total reclassifications					395,881		500
	Code letter - C							
1	TO RECLASS BOND AMORITZATION	D	Cap Rel Costs-Bldg & Fixt	1		17,040	9	1
2							9	2
3							9	3
500	Total reclassifications					17,040		500
	Code letter - D							
1	TO RECLASS DEPRECIATION EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		330,766	9	1
2			Cap Rel Costs-Mvble Equip	2		41,032	9	2
500	Total reclassifications					371,798		500
	Code letter - E							
1	TO RECLASS DEPRECIATION EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		31,953	9	1
2			Cap Rel Costs-Mvble Equip	2		1,579	9	2
500	Total reclassifications					33,532		500
	Code letter - F							
1	RECLASS PT COSTS TO OT & SP	G	Physical Therapy	66	90,609	7,019		1
2								2
500	Total reclassifications				90,609	7,019		500
	Code letter - G							
	GRAND TOTAL (Decreases)				195,858	893,928		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	3,116					3,116		1
2	Land Improvements	1,212,116					1,212,116		2
3	Buildings and Fixtures	7,405,330	1,527		1,527		7,406,857		3
4	Building Improvements								4
5	Fixed Equipment	6,546,837	193,409		193,409		6,740,246		5
6	Movable Equipment	4,916,827	68,339		68,339	16,850	4,968,316		6
7	HIT-designated Assets	1,930,302	40,232		40,232		1,970,534		7
8	Subtotal (sum of lines 1-7)	22,014,528	303,507		303,507	16,850	22,301,185		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	22,014,528	303,507		303,507	16,850	22,301,185		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	712,973						712,973	1
1.01	2008 BLDG & FIXT								1.01
1.02	RHC BLDG & FIXT								1.02
2	Cap Rel Costs-Mvble Equip	624,037						624,037	2
2.01	2008 MVBLE EQUIP								2.01
2.02	RHC MVBLE EQUIP								2.02
3	Total (sum of lines 1-2)	1,337,010						1,337,010	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may
have been included in Worksheet A, column 2, lines 1 and 2.
* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	8,959,317		8,959,317	0.401742			13,509	13,509	1
1.01	2008 BLDG & FIXT	6,209,605		6,209,605	0.278443			9,363	9,363	1.01
1.02	RHC BLDG & FIXT				0.000000					1.02
2	Cap Rel Costs-Mvble Equ	6,563,063		6,563,063	0.294292			9,896	9,896	2
2.01	2008 MVBLE EQUIP	569,200		569,200	0.025523			858	858	2.01
2.02	RHC MVBLE EQUIP				0.000000					2.02
3	Total (sum of lines 1-2)	22,301,185		22,301,185	1.000000			33,626	33,626	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	333,214		139,794			13,509	486,517	1
1.01	2008 BLDG & FIXT	344,649		136,890			9,363	490,902	1.01

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1.02	RHC BLDG & FIXT	31,953						31,953	1.02
2	Cap Rel Costs-Mvble Equip	226,795		96,809			9,896	333,500	2
2.01	2008 MVBLE EQUIP	42,239		11,903			858	55,000	2.01
2.02	RHC MVBLE EQUIP	1,579						1,579	2.02
3	Total (sum of lines 1-2)	980,429		385,396			33,626	1,399,451	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.)

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	-55	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)	B	-367	Cap Rel Costs-Mvble Equip	2	11	2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-634,426				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-40,664	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients	B	-57,753	Pharmacy	15		17
18	Sale of medical records and abstracts	B	-1,086	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-356,581	Cap Rel Costs-Mvble Equip	2	9	32
33	MISCELLANEOUS INCOME	B	-62,959	Administrative & General	5		33
34							34
35	AHA DUES USED FOR LOBBYING	A	-1,057	Administrative & General	5		35
36	IHA DUES USED FOR LOBBYING	A	-9,066	Administrative & General	5		36
37	MARKETING	A	-58,763	Administrative & General	5		37
38							38
39	DR. HALL SHARED EXPENSES	A	-183,546	Physicians' Private Offices	192		39
40	DEPRECIATION	A	-10,063	Cap Rel Costs-Bldg & Fixt	1	11	40
41	DEPRECIATION	A	411	Administrative & General	5		41
42							42
43	DEPRECIATION	A	-470	Operation of Plant	7		43
44	DEPRECIATION	A	-157	Housekeeping	9		44
45	DEPRECIATION	A	-480	Dietary	10		45
45.01	DEPRECIATION	A	-1,316	Nursing Administration	13		45.01
45.02	DEPRECIATION	A	-437	Pharmacy	15		45.02
45.03	DEPRECIATION	A	-82	Social Service	17		45.03
45.04	DEPRECIATION	A	-3,736	Adults & Pediatrics	30		45.04
45.05	DEPRECIATION	A	-2,545	Operating Room	50		45.05
45.06	DEPRECIATION	A	5,069	Radiology-Diagnostic	54		45.06
45.07	DEPRECIATION	A	-2,007	CARDIAC REHABILITATION	73.01		45.07
45.08	DEPRECIATION	A	1,494	Laboratory	60		45.08
45.09	DEPRECIATION	A	4,551	Respiratory Therapy	65		45.09
45.10	DEPRECIATION	A	2,672	Physical Therapy	66		45.10
45.11	DEPRECIATION	A	-1,557	Emergency	91		45.11
45.12	DEPRECIATION	A	-281	Rural Health Clinic	88		45.12

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS / CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
45.13	DEPRECIATION	A	-1,330	Physicians' Private Offices	192		45.13
45.14	DEPRECIATION	A	-30	INDEPENDENT LIVING	192.02		45.14
45.16	SWAP UNALLOWABLE INTEREST	A	-231,293	Interest Expense	113		45.16
45.17	HOSPITALIST PHYSICAN FEES	A	-386,888	Adults & Pediatrics	30		45.17
46							46
47	PROVIDER TAX ASSESSMENT	A	-285,851	Administrative & General	5		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,320,649				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.

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

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

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

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

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

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

				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							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:

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	91	Emergency AGGREGATE	1,019,978	634,426	385,552					1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,019,978	634,426	385,552					200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	91	Emergency AGGREGATE							634,426	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							634,426	200

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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)						1
2	Line 1 multiplied by 15 hours per week						2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					2	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					22.65	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		3.25				9
10	AHSEA (see instructions)		74.81				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)	37.41	37.41				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)	243	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)	243	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)	243	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	243	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)	75	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)	75	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	45	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	120	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)	120	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	243	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	120	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)	363	63
64	Total cost of outside supplier services (from provider records)	179	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					95	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					23.91	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		389.00				9
10	AHSEA (see instructions)		78.94				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)	39.47	39.47				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)	30,708	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)	30,708	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)	30,708	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)	78.94	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	61,573	22
23	Total salary equivalency (see instructions)	61,573	23

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

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)	3,750	24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	3,750	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	2,271	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,021	28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)	6,021	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	61,573	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	6,021	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)	67,594	63
64	Total cost of outside supplier services (from provider records)	22,562	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)						1
2	Line 1 multiplied by 15 hours per week						2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					1	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					21.77	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		2.00				9
10	AHSEA (see instructions)		71.87				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)	35.94	35.94				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)	144	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)	144	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)	144	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	144	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)	36	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)	36	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	22	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	58	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)	58	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	144	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	58	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)	202	63
64	Total cost of outside supplier services (from provider records)	90	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP BLDGS + FIXTURES	CAP REL COSTS-BLDG & FIX	CAP MOVABLE EQUIPMENT	CAP MOVABLE EQUIPMENT	
		0	1	1.01	1.02	2	2.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	486,517	486,517					1
1.01	2008 BLDG & FIXT	490,902		490,902				1.01
1.02	RHC BLDG & FIXT	31,953			31,953			1.02
2	Cap Rel Costs-Mvble Equip	333,500				333,500		2
2.01	2008 MVBLE EQUIP	55,000					55,000	2.01
2.02	RHC MVBLE EQUIP	1,579						2.02
4	Employee Benefits Department	1,981,010						4
5	Administrative & General	1,807,089	131,134	13,133		104,904		5
6	Maintenance & Repairs	309,566						6
7	Operation of Plant	217,117	41,717	4,627		1,694		7
8	Laundry & Linen Service	52,490	16,378			446		8
9	Housekeeping	257,076	9,341			1,667		9
10	Dietary	166,607	19,622			524		10
11	Cafeteria	133,243	5,829			524		11
12	Maintenance of Personnel							12
13	Nursing Administration	517,545	4,758			967		13
14	Central Services & Supply							14
15	Pharmacy	840,779		26,947		1,907	7,717	15
16	Medical Records & Library	223,967	10,281			3,447		16
17	Social Service	29,872	1,009					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,040,796		275,710		24,346	40,004	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	298,694		125,550		53,012	1,809	50
53	Anesthesiology	240,000						53
54	Radiology-Diagnostic	936,179	10,487			75,499		54
60	Laboratory	731,107	2,946	44,935		16,892	5,470	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	276,070	15,948			13,646		65
66	Physical Therapy	501,443	21,366			6,558		66
67	Occupational Therapy	84,417	4,010			1,093		67
68	Speech Pathology	13,211	878			157		68
69	Electrocardiology	32,382	467					69
71	Medical Supplies Charged to Patients	542,792						71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION	46,594	4,129			10,023		73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	721,417			31,953			88
91	Emergency	922,447	17,860			13,316		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	14,323,361	318,160	490,902	31,953	330,622	55,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,088					190
192	Physicians' Private Offices	541,913	33,578			2,058		192
192.02	INDEPENDENT LIVING	185,764	129,691			820		192.02
192.03	MEALS ON WHEELS							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	15,051,038	486,517	490,902	31,953	333,500	55,000	202

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

	COST CENTER DESCRIPTIONS	CAP MVBLE EQUI	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
		2.02	4	4A	5	6	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP	1,579						2.02
4	Employee Benefits Department		1,981,010					4
5	Administrative & General		258,041	2,314,301	2,314,301			5
6	Maintenance & Repairs		50,378	359,944	65,403	425,347		6
7	Operation of Plant			265,155	48,179		313,334	7
8	Laundry & Linen Service		3,792	73,106	13,284	3,426	16,350	8
9	Housekeeping		61,997	330,081	59,977	11,419	9,325	9
10	Dietary		28,138	214,891	39,046	25,692	19,589	10
11	Cafeteria		29,286	168,882	30,686		5,819	11
12	Maintenance of Personnel							12
13	Nursing Administration		139,963	663,233	120,511		4,750	13
14	Central Services & Supply							14
15	Pharmacy		62,134	939,484	170,707	4,567	7,385	15
16	Medical Records & Library		54,323	292,018	53,061	6,280	10,264	16
17	Social Service		8,319	39,200	7,123		1,007	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		263,457	1,644,313	298,773	222,094	75,564	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		62,295	541,360	98,367	10,277	34,409	50
53	Anesthesiology			240,000	43,609			53
54	Radiology-Diagnostic		121,209	1,143,374	207,754	24,550	10,469	54
60	Laboratory		127,819	929,169	168,833	27,405	15,256	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		59,389	365,053	66,331	30,831	15,921	65
66	Physical Therapy		128,809	658,176	119,593	4,567	26,210	66
67	Occupational Therapy		21,801	111,321	20,227	1,142		67
68	Speech Pathology		3,412	17,658	3,209	571		68
69	Electrocardiology		7,316	40,165	7,298		466	69
71	Medical Supplies Charged to Patients			542,792	98,627			71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION		12,978	73,724	13,396	2,284	4,122	73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,579	179,651	934,600	169,820	7,993		88
91	Emergency		144,568	1,098,191	199,545	15,415	17,829	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,579	1,829,075	14,000,191	2,123,359	398,513	274,735	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			5,088	925		5,079	190
192	Physicians' Private Offices		132,815	710,364	129,075	6,280	33,520	192
192.02	INDEPENDENT LIVING		19,120	335,395	60,942	20,554		192.02
192.03	MEALS ON WHEELS							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,579	1,981,010	15,051,038	2,314,301	425,347	313,334	202

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	106,166						8
9	Housekeeping	923	411,725					9
10	Dietary	1,366	40,927	341,511				10
11	Cafeteria	1,443			206,830			11
12	Maintenance of Personnel							12
13	Nursing Administration				14,073	802,567		13
14	Central Services & Supply							14
15	Pharmacy		3,625		6,110		1,131,878	15
16	Medical Records & Library		3,508		12,776			16
17	Social Service				1,296			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	66,348	244,156	307,655	46,295	510,787		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,810	22,101		8,332	92,176		50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,943	17,657		17,035			54
60	Laboratory	1,096	17,774		20,368			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,328	9,589		9,073			65
66	Physical Therapy	9,522	9,706		15,739			66
67	Occupational Therapy	1,577	1,637		2,592			67
68	Speech Pathology	231	234		370			68
69	Electrocardiology				370			69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients						1,131,878	73
73.01	CARDIAC REHABILITATION				1,666			73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,308	10,524		17,220			88
91	Emergency	7,271	18,242		18,146	199,604		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	106,166	399,680	307,655	191,461	802,567	1,131,878	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		11,343		11,110			192
192.02	INDEPENDENT LIVING		702		4,259			192.02
192.03	MEALS ON WHEELS			33,856				192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	106,166	411,725	341,511	206,830	802,567	1,131,878	202

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	377,907						16
17	Social Service		48,626					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	121,103	48,626	3,585,714		3,585,714		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	11,110		825,942		825,942		50
53	Anesthesiology			283,609		283,609		53
54	Radiology-Diagnostic	18,887		1,442,669		1,442,669		54
60	Laboratory	39,521		1,219,422		1,219,422		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	16,189		517,315		517,315		65
66	Physical Therapy	24,125		867,638		867,638		66
67	Occupational Therapy	3,968		142,464		142,464		67
68	Speech Pathology	635		22,908		22,908		68
69	Electrocardiology			48,299		48,299		69
71	Medical Supplies Charged to Patients			641,419		641,419		71
73	Drugs Charged to Patients			1,131,878		1,131,878		73
73.01	CARDIAC REHABILITATION	1,111		96,303		96,303		73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	45,393		1,186,858		1,186,858		88
91	Emergency	66,820		1,641,063		1,641,063		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	348,862	48,626	13,653,501		13,653,501		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			11,092		11,092		190
192	Physicians' Private Offices	29,045		930,737		930,737		192
192.02	INDEPENDENT LIVING			421,852		421,852		192.02
192.03	MEALS ON WHEELS			33,856		33,856		192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	377,907	48,626	15,051,038		15,051,038		202

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP BLDGS + FIXTURES	CAP REL COSTS-BLDG & FIX	CAP MOVABLE EQUIPMENT	CAP MOVABLE EQUIPMENT	
		0	1	1.01	1.02	2	2.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General		131,134	13,133		104,904		5
6	Maintenance & Repairs							6
7	Operation of Plant		41,717	4,627		1,694		7
8	Laundry & Linen Service		16,378			446		8
9	Housekeeping		9,341			1,667		9
10	Dietary		19,622			524		10
11	Cafeteria		5,829			524		11
12	Maintenance of Personnel							12
13	Nursing Administration		4,758			967		13
14	Central Services & Supply							14
15	Pharmacy			26,947		1,907	7,717	15
16	Medical Records & Library		10,281			3,447		16
17	Social Service		1,009					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			275,710		24,346	40,004	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			125,550		53,012	1,809	50
53	Anesthesiology							53
54	Radiology-Diagnostic		10,487			75,499		54
60	Laboratory		2,946	44,935		16,892	5,470	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		15,948			13,646		65
66	Physical Therapy		21,366			6,558		66
67	Occupational Therapy		4,010			1,093		67
68	Speech Pathology		878			157		68
69	Electrocardiology		467					69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION		4,129			10,023		73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				31,953			88
91	Emergency		17,860			13,316		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		318,160	490,902	31,953	330,622	55,000	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,088					190
192	Physicians' Private Offices		33,578			2,058		192
192.02	INDEPENDENT LIVING		129,691			820		192.02
192.03	MEALS ON WHEELS							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		486,517	490,902	31,953	333,500	55,000	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAP MVBLE EQUI	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		2.02	2A	5	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General		249,171	249,171				5
6	Maintenance & Repairs			7,042	7,042			6
7	Operation of Plant		48,038	5,187		53,225		7
8	Laundry & Linen Service		16,824	1,430	57	2,777	21,088	8
9	Housekeeping		11,008	6,457	189	1,584	183	9
10	Dietary		20,146	4,204	425	3,327	271	10
11	Cafeteria		6,353	3,304		988	287	11
12	Maintenance of Personnel							12
13	Nursing Administration		5,725	12,975		807		13
14	Central Services & Supply							14
15	Pharmacy		36,571	18,379	76	1,255		15
16	Medical Records & Library		13,728	5,713	104	1,743		16
17	Social Service		1,009	767		171		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		340,060	32,168	3,678	12,838	13,179	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		180,371	10,591	170	5,845	1,551	50
53	Anesthesiology			4,695				53
54	Radiology-Diagnostic		85,986	22,368	406	1,778	585	54
60	Laboratory		70,243	18,177	454	2,591	218	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		29,594	7,142	510	2,704	860	65
66	Physical Therapy		27,924	12,876	76	4,452	1,891	66
67	Occupational Therapy		5,103	2,178	19		313	67
68	Speech Pathology		1,035	345	9		46	68
69	Electrocardiology		467	786		79		69
71	Medical Supplies Charged to Patients			10,619				71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION		14,152	1,442	38	700		73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,579	33,532	18,284	132		260	88
91	Emergency		31,176	21,484	255	3,029	1,444	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,579	1,228,216	228,613	6,598	46,668	21,088	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,088	100		863		190
192	Physicians' Private Offices		35,636	13,897	104	5,694		192
192.02	INDEPENDENT LIVING		130,511	6,561	340			192.02
192.03	MEALS ON WHEELS							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,579	1,399,451	249,171	7,042	53,225	21,088	202

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	19,421						9
10	Dietary	1,931	30,304					10
11	Cafeteria			10,932				11
12	Maintenance of Personnel							12
13	Nursing Administration			744	20,251			13
14	Central Services & Supply							14
15	Pharmacy	171		323		56,775		15
16	Medical Records & Library	165		675			22,128	16
17	Social Service			69				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,519	27,300	2,446	12,888		7,090	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,042		440	2,326		651	50
53	Anesthesiology							53
54	Radiology-Diagnostic	833		900			1,106	54
60	Laboratory	838		1,077			2,314	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	452		480			948	65
66	Physical Therapy	458		832			1,413	66
67	Occupational Therapy	77		137			232	67
68	Speech Pathology	11		20			37	68
69	Electrocardiology			20				69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients					56,775		73
73.01	CARDIAC REHABILITATION			88			65	73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	496		910			2,658	88
91	Emergency	860		959	5,037		3,913	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	18,853	27,300	10,120	20,251	56,775	20,427	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	535		587			1,701	192
192.02	INDEPENDENT LIVING	33		225				192.02
192.03	MEALS ON WHEELS		3,004					192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	19,421	30,304	10,932	20,251	56,775	22,128	202

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		17	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	2,016						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	2,016	465,182		465,182			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		202,987		202,987			50
53	Anesthesiology		4,695		4,695			53
54	Radiology-Diagnostic		113,962		113,962			54
60	Laboratory		95,912		95,912			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		42,690		42,690			65
66	Physical Therapy		49,922		49,922			66
67	Occupational Therapy		8,059		8,059			67
68	Speech Pathology		1,503		1,503			68
69	Electrocardiology		1,352		1,352			69
71	Medical Supplies Charged to Patients		10,619		10,619			71
73	Drugs Charged to Patients		56,775		56,775			73
73.01	CARDIAC REHABILITATION		16,485		16,485			73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		56,272		56,272			88
91	Emergency		68,157		68,157			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	2,016	1,194,572		1,194,572			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		6,051		6,051			190
192	Physicians' Private Offices		58,154		58,154			192
192.02	INDEPENDENT LIVING		137,670		137,670			192.02
192.03	MEALS ON WHEELS		3,004		3,004			192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,016	1,399,451		1,399,451			202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP BLDGS + FIXTURES SQUARE FEET	CAP REL COSTS-BLDG & FIX SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	CAP MOVABLE EQUIPMENT DOLLAR VALUE	CAP MVBLE EQUI DOLLAR VALUE	
		1	1.01	1.02	2	2.01	2.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	78,126						1
1.01	2008 BLDG & FIXT		21,642					1.01
1.02	RHC BLDG & FIXT			4,575				1.02
2	Cap Rel Costs-Mvble Equip				249,045			2
2.01	2008 MVBLE EQUIP					16,570		2.01
2.02	RHC MVBLE EQUIP						1,841	2.02
4	Employee Benefits Department							4
5	Administrative & General	21,058	579		78,340			5
6	Maintenance & Repairs							6
7	Operation of Plant	6,699	204		1,265			7
8	Laundry & Linen Service	2,630			333			8
9	Housekeeping	1,500			1,245			9
10	Dietary	3,151			391			10
11	Cafeteria	936			391			11
12	Maintenance of Personnel							12
13	Nursing Administration	764			722			13
14	Central Services & Supply							14
15	Pharmacy		1,188		1,424	2,325		15
16	Medical Records & Library	1,651			2,574			16
17	Social Service	162						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		12,155		18,181	12,052		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,535		39,587	545		50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,684			56,380			54
60	Laboratory	473	1,981		12,614	1,648		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,561			10,190			65
66	Physical Therapy	3,431			4,897			66
67	Occupational Therapy	644			816			67
68	Speech Pathology	141			117			68
69	Electrocardiology	75						69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION	663			7,485			73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			4,575			1,841	88
91	Emergency	2,868			9,944			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	51,091	21,642	4,575	246,896	16,570	1,841	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	817						190
192	Physicians' Private Offices	5,392			1,537			192
192.02	INDEPENDENT LIVING	20,826			612			192.02
192.03	MEALS ON WHEELS							192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	486,517	490,902	31,953	333,500	55,000	1,579	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.227338	22.682839	6.984262	1.339115	3.319252	0.857686	203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

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

	COST CENTER DESCRIPTIONS	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS TIME SPENT	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	
		4	5A	5	6	7	8	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department	7,119,296						4
5	Administrative & General	927,342	-2,314,301	12,736,737				5
6	Maintenance & Repairs	181,046		359,944	745			6
7	Operation of Plant			265,155		50,402		7
8	Laundry & Linen Service	13,628		73,106	6	2,630	5,519	8
9	Housekeeping	222,805		330,081	20	1,500	48	9
10	Dietary	101,122		214,891	45	3,151	71	10
11	Cafeteria	105,249		168,882		936	75	11
12	Maintenance of Personnel							12
13	Nursing Administration	502,997		663,233		764		13
14	Central Services & Supply							14
15	Pharmacy	223,297		939,484	8	1,188		15
16	Medical Records & Library	195,226		292,018	11	1,651		16
17	Social Service	29,898		39,200		162		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	946,790		1,644,313	389	12,155	3,449	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	223,873		541,360	18	5,535	406	50
53	Anesthesiology			240,000				53
54	Radiology-Diagnostic	435,599		1,143,374	43	1,684	153	54
60	Laboratory	459,353		929,169	48	2,454	57	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	213,430		365,053	54	2,561	225	65
66	Physical Therapy	462,911		658,176	8	4,216	495	66
67	Occupational Therapy	78,348		111,321	2		82	67
68	Speech Pathology	12,261		17,658	1		12	68
69	Electrocardiology	26,293		40,165		75		69
71	Medical Supplies Charged to Patients			542,792				71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION	46,640		73,724	4	663		73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	645,624		934,600	14		68	88
91	Emergency	519,543		1,098,191	27	2,868	378	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	6,573,275	-2,314,301	11,685,890	698	44,193	5,519	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			5,088		817		190
192	Physicians' Private Offices	477,308		710,364	11	5,392		192
192.02	INDEPENDENT LIVING	68,713		335,395	36			192.02
192.03	MEALS ON WHEELS							192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,981,010		2,314,301	425,347	313,334	106,166	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.278259		0.181703	570.935570	6.216698	19.236456	203
204	Cost to be allocated (Per Wkst. B, Part II)			249,171	7,042	53,225	21,088	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.019563	9.452349	1.056010	3.820982	205

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING TIME SPENT	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	NURSING ADMINIS-TRATION HOURS SUPE RVISED	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	3,521						9
10	Dietary	350	11,933					10
11	Cafeteria			1,117				11
12	Maintenance of Personnel							12
13	Nursing Administration			76	81,819			13
14	Central Services & Supply							14
15	Pharmacy	31		33		1,000		15
16	Medical Records & Library	30		69			2,381	16
17	Social Service			7				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	2,088	10,750	250	52,073		763	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	189		45	9,397		70	50
53	Anesthesiology							53
54	Radiology-Diagnostic	151		92			119	54
60	Laboratory	152		110			249	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	82		49			102	65
66	Physical Therapy	83		85			152	66
67	Occupational Therapy	14		14			25	67
68	Speech Pathology	2		2			4	68
69	Electrocardiology			2				69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients					1,000		73
73.01	CARDIAC REHABILITATION			9			7	73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	90		93			286	88
91	Emergency	156		98	20,349		421	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	3,418	10,750	1,034	81,819	1,000	2,198	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices	97		60			183	192
192.02	INDEPENDENT LIVING	6		23				192.02
192.03	MEALS ON WHEELS		1,183					192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	411,725	341,511	206,830	802,567	1,131,878	377,907	202
203	Unit Cost Multiplier (Wkst. B, Part I)	116.934110	28.619040	185.165622	9.809054	1,131.878000	158.717766	203
204	Cost to be allocated (Per Wkst. B, Part II)	19,421	30,304	10,932	20,251	56,775	22,128	204
205	Unit Cost Multiplier (Wkst. B, Part II)	5.515763	2.539512	9.786929	0.247510	56.775000	9.293574	205

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME SPENT						
		17						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	100						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	100						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION							73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.02	INDEPENDENT LIVING							192.02
192.03	MEALS ON WHEELS							192.03
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	48,626						202
203	Unit Cost Multiplier (Wkst. B, Part I)	486.260000						203
204	Cost to be allocated (Per Wkst. B, Part II)	2,016						204
205	Unit Cost Multiplier (Wkst. B, Part II)	20.160000						205

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,585,714		3,585,714		3,585,714	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	825,942		825,942		825,942	50
53	Anesthesiology	283,609		283,609		283,609	53
54	Radiology-Diagnostic	1,442,669		1,442,669		1,442,669	54
60	Laboratory	1,219,422		1,219,422		1,219,422	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	517,315		517,315		517,315	65
66	Physical Therapy	867,638		867,638		867,638	66
67	Occupational Therapy	142,464		142,464		142,464	67
68	Speech Pathology	22,908		22,908		22,908	68
69	Electrocardiology	48,299		48,299		48,299	69
71	Medical Supplies Charged to Patients	641,419		641,419		641,419	71
73	Drugs Charged to Patients	1,131,878		1,131,878		1,131,878	73
73.01	CARDIAC REHABILITATION	96,303		96,303		96,303	73.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	1,186,858		1,186,858		1,186,858	88
91	Emergency	1,641,063		1,641,063		1,641,063	91
92	Observation Beds (Non-Distinct Part)	205,652		205,652		205,652	92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	13,859,153		13,859,153		13,859,153	200
201	Less Observation Beds	205,652		205,652		205,652	201
202	Total (line 200 minus line 201)	13,653,501		13,653,501		13,653,501	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	949,789		949,789				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	92,611	749,577	842,188	0.980710	0.980710	0.980710	50
53	Anesthesiology	58,395	266,866	325,261	0.871943	0.871943	0.871943	53
54	Radiology-Diagnostic	876,348	7,272,499	8,148,847	0.177040	0.177040	0.177040	54
60	Laboratory	1,652,407	5,893,694	7,546,101	0.161596	0.161596	0.161596	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	780,272	562,835	1,343,107	0.385163	0.385163	0.385163	65
66	Physical Therapy	239,023	1,838,068	2,077,091	0.417718	0.417718	0.417718	66
67	Occupational Therapy	105,582	228,269	333,851	0.426729	0.426729	0.426729	67
68	Speech Pathology	19,488	120,159	139,647	0.164042	0.164042	0.164042	68
69	Electrocardiology	162,065	434,674	596,739	0.080938	0.080938	0.080938	69
71	Medical Supplies Charged to Patients	792,872	578,843	1,371,715	0.467604	0.467604	0.467604	71
73	Drugs Charged to Patients	1,090,427	1,378,077	2,468,504	0.458528	0.458528	0.458528	73
73.01	CARDIAC REHABILITATION		296,568	296,568	0.324725	0.324725	0.324725	73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		629,741	629,741				88
91	Emergency	174,563	2,112,310	2,286,873	0.717601	0.717601	0.717601	91
92	Observation Beds (Non-Distinct Part)	215,470	483,081	698,551	0.294398	0.294398	0.294398	92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	7,209,312	22,845,261	30,054,573				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	7,209,312	22,845,261	30,054,573				202

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1331** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.980710		204,979			201,025		50
53	Anesthesiology	0.871943		94,316			82,238		53
54	Radiology-Diagnostic	0.177040		2,658,371			470,638		54
60	Laboratory	0.161596		2,433,512			393,246		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.385163		119,249			45,930		65
66	Physical Therapy	0.417718		596,879			249,327		66
67	Occupational Therapy	0.426729		49,865			21,279		67
68	Speech Pathology	0.164042		23,096			3,789		68
69	Electrocardiology	0.080938		102,930			8,331		69
71	Medical Supplies Charged to Pat	0.467604		421,382			197,040		71
73	Drugs Charged to Patients	0.458528		922,233			422,870		73
73.01	CARDIAC REHABILITATION	0.324725		125,446			40,735		73.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.717601		623,840			447,668		91
92	Observation Beds (Non-Distinct	0.294398		237,221			69,837		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			8,613,319			2,653,953		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			8,613,319			2,653,953		202

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z331** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.980710							50
53	Anesthesiology	0.871943							53
54	Radiology-Diagnostic	0.177040							54
60	Laboratory	0.161596							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.385163							65
66	Physical Therapy	0.417718							66
67	Occupational Therapy	0.426729							67
68	Speech Pathology	0.164042							68
69	Electrocardiology	0.080938							69
71	Medical Supplies Charged to Pat	0.467604							71
73	Drugs Charged to Patients	0.458528							73
73.01	CARDIAC REHABILITATION	0.324725							73.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.717601							91
92	Observation Beds (Non-Distinct	0.294398							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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	465,182	195,269	269,913	1,386	194.74	148	28,822	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)	465,182		269,913	1,386		148	28,822	200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1331** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	202,987	842,188	0.241023	41,581	10,022	50
53	Anesthesiology	4,695	325,261	0.014435	25,517	368	53
54	Radiology-Diagnostic	113,962	8,148,847	0.013985	124,662	1,743	54
60	Laboratory	95,912	7,546,101	0.012710	135,880	1,727	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	42,690	1,343,107	0.031785	47,062	1,496	65
66	Physical Therapy	49,922	2,077,091	0.024035	1,094	26	66
67	Occupational Therapy	8,059	333,851	0.024140			67
68	Speech Pathology	1,503	139,647	0.010763			68
69	Electrocardiology	1,352	596,739	0.002266	6,939	16	69
71	Medical Supplies Charged to Pat	10,619	1,371,715	0.007741	97,706	756	71
73	Drugs Charged to Patients	56,775	2,468,504	0.023000	68,817	1,583	73
73.01	CARDIAC REHABILITATION	16,485	296,568	0.055586			73.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	56,272	629,741	0.089357			88
91	Emergency	68,157	2,286,873	0.029804	37,632	1,122	91
92	Observation Beds (Non-Distinct	45,981	698,551	0.065823	36,746	2,419	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	775,371	29,104,784		623,636	21,278	200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V
[XX] Title XIX
[XX] PPS
[ ] TEFRA
[ ] Other

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

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,386		148		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	1,386		148		200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1331** | **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/IID | [XX] PPS [ ] TEFRA [ ] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION							73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1331** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	842,188			41,581				50
53	Anesthesiology	325,261			25,517				53
54	Radiology-Diagnostic	8,148,847			124,662				54
60	Laboratory	7,546,101			135,880				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,343,107			47,062				65
66	Physical Therapy	2,077,091			1,094				66
67	Occupational Therapy	333,851							67
68	Speech Pathology	139,647							68
69	Electrocardiology	596,739			6,939				69
71	Medical Supplies Charged to Pat	1,371,715			97,706				71
73	Drugs Charged to Patients	2,468,504			68,817				73
73.01	CARDIAC REHABILITATION	296,568							73.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	629,741							88
91	Emergency	2,286,873			37,632				91
92	Observation Beds (Non-Distinct	698,551			36,746				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	29,104,784			623,636				200

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1331** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.980710							50
53	Anesthesiology	0.871943							53
54	Radiology-Diagnostic	0.177040							54
60	Laboratory	0.161596							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.385163							65
66	Physical Therapy	0.417718							66
67	Occupational Therapy	0.426729							67
68	Speech Pathology	0.164042							68
69	Electrocardiology	0.080938							69
71	Medical Supplies Charged to Pat	0.467604							71
73	Drugs Charged to Patients	0.458528							73
73.01	CARDIAC REHABILITATION	0.324725							73.01
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
91	Emergency	0.717601							91
92	Observation Beds (Non-Distinct	0.294398							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1331** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,630	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,386	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,249	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	490	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)	490	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	132	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)	132	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	810	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)	450	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)	449	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	127.60	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	130.60	20
21	Total general inpatient routine service cost (see instructions)	3,585,714	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)	16,843	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	17,239	25
26	Total swing-bed cost (see instructions)	1,505,170	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,080,544	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,080,544	37

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1331** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,501.11	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,215,899	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)					1,215,899	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					623,417	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,839,316	49

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	675,500	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	673,998	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	1,349,498	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

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1331** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					137	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,501.11	88
89	Observation bed cost (line 87 x line 88) (see instructions)					205,652	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	465,182	2,080,544	0.223587	205,652	45,981	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1331** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,630	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,386	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,249	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	490	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)	490	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	132	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)	132	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	148	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	127.60	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	130.60	20
21	Total general inpatient routine service cost (see instructions)	3,585,714	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)	16,843	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	17,239	25
26	Total swing-bed cost (see instructions)	1,505,170	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,080,544	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,080,544	37

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1331** **WORKSHEET D-1 PART II**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[XX] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**		**[ ] 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)					1,501.11	38
39	Program general inpatient routine service cost (line 9 x line 38)					222,164	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)					222,164	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					241,268	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					463,432	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					28,822	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					21,278	51
52	Total Program excludable cost (sum of lines 50 and 51)					50,100	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					413,332	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1331** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					137	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1331** **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/IID**
[ ] 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		611,510		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.980710	16,540	16,221	50
53	Anesthesiology	0.871943	11,951	10,421	53
54	Radiology-Diagnostic	0.177040	244,780	43,336	54
60	Laboratory	0.161596	598,714	96,750	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.385163	311,750	120,075	65
66	Physical Therapy	0.417718	33,281	13,902	66
67	Occupational Therapy	0.426729	7,499	3,200	67
68	Speech Pathology	0.164042	5,799	951	68
69	Electrocardiology	0.080938	78,677	6,368	69
71	Medical Supplies Charged to Patients	0.467604	291,234	136,182	71
73	Drugs Charged to Patients	0.458528	343,775	157,630	73
73.01	CARDIAC REHABILITATION	0.324725			73.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.717601	17,625	12,648	91
92	Observation Beds (Non-Distinct Part)	0.294398	19,472	5,733	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,981,097	623,417	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,981,097		202

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z331** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.980710			50
53	Anesthesiology	0.871943			53
54	Radiology-Diagnostic	0.177040	69,347	12,277	54
60	Laboratory	0.161596	342,547	55,354	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.385163	195,852	75,435	65
66	Physical Therapy	0.417718	141,618	59,156	66
67	Occupational Therapy	0.426729	69,329	29,585	67
68	Speech Pathology	0.164042	12,281	2,015	68
69	Electrocardiology	0.080938	15,240	1,233	69
71	Medical Supplies Charged to Patients	0.467604	198,438	92,790	71
73	Drugs Charged to Patients	0.458528	419,965	192,566	73
73.01	CARDIAC REHABILITATION	0.324725			73.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.717601			91
92	Observation Beds (Non-Distinct Part)	0.294398			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,464,617	520,411	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,464,617		202

(A) Worksheet A line numbers

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1331** **WORKSHEET D-3**

Check Applicable Boxes:

[ ] Title V	[XX] Hospital	[ ] SUB (Other)	[ ] Swing Bed SNF	[XX] PPS
[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[XX] Title XIX	[ ] IRF	[ ] NF	[ ] ICF/IID	[ ] 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		153,343		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.980710	41,581	40,779	50
53	Anesthesiology	0.871943	25,517	22,249	53
54	Radiology-Diagnostic	0.177040	124,662	22,070	54
60	Laboratory	0.161596	135,880	21,958	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.385163	47,062	18,127	65
66	Physical Therapy	0.417718	1,094	457	66
67	Occupational Therapy	0.426729			67
68	Speech Pathology	0.164042			68
69	Electrocardiology	0.080938	6,939	562	69
71	Medical Supplies Charged to Patients	0.467604	97,706	45,688	71
73	Drugs Charged to Patients	0.458528	68,817	31,555	73
73.01	CARDIAC REHABILITATION	0.324725			73.01
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
91	Emergency	0.717601	37,632	27,005	91
92	Observation Beds (Non-Distinct Part)	0.294398	36,746	10,818	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		623,636	241,268	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		623,636		202

(A) Worksheet A line numbers

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1331** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	2,653,953			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,653,953			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	2,680,493			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	35,020			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,252,710			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,392,763			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,392,763			30
31	Primary payer payments	71			31
32	Subtotal (line 30 minus line 31)	1,392,692			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)	244,184			34
35	Adjusted reimbursable bad debts (see instructions)	185,580			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	244,184			36
37	Subtotal (see instructions)	1,578,272			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,578,272			40
40.01	Sequestration adjustment (see instructions)	31,565			40.01
41	Interim payments	1,686,873			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-140,166			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	49,899			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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1331** **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				1,591,910		1,644,673	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	02/01/2015	37,600	02/01/2015	42,200	3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					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		37,600		42,200	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)				1,629,510		1,686,873	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		41,493			6.01
	based on the cost report (1)		.02				-140,166	6.02
7	Total Medicare program liability (see instructions)				1,671,003		1,546,707	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.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z331** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,648,988			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	02/01/2015	58,100			3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					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		58,100			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)				1,707,088			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		129,169			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,836,257			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.

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	475	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	810	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	41	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,249	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	30,054,573	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	180,616	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z331** **WORKSHEET E-2**

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	1,362,993		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	525,615		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	899		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,888,608		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,888,608		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,888,608		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	14,876		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,873,732		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	1,873,732		19
19.01	Sequestration adjustment (see instructions)	37,475		19.01
20	Interim payments	1,707,088		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	129,169		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2	35,403		23

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

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

1	Inpatient services	1,839,316	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,839,316	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,857,709	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,857,709	19
20	Deductibles (exclude professional component)	179,796	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,677,913	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,677,913	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	35,779	25
26	Adjusted reimbursable bad debts (see instructions)	27,192	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	35,779	27
28	Subtotal (sum of lines 24 and 26)	1,705,105	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,705,105	30
30.01	Sequestration adjustment (see instructions)	34,102	30.01
31	Interim payments	1,629,510	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	41,493	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	34,801	34

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1331** **WORKSHEET E-3 PART VII**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[XX] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[ ] 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			1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	623,636		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)	623,636		12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	623,636		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	1,086,261				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	3,655,092				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-840,000				6
7	Inventory	546,090				7
8	Prepaid expenses	2,201,868				8
9	Other current assets	15,000				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	6,664,311				11
	FIXED ASSETS					
12	Land	3,114				12
13	Land improvements	1,212,116				13
14	Accumulated depreciation	-808,237				14
15	Buildings	7,406,858				15
16	Accumulated depreciation	-3,321,835				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	6,830,024				19
20	Accumulated depreciation	-3,920,879				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,968,320				23
24	Accumulated depreciation	-4,310,591				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,970,534				27
28	Accumulated depreciation	-442,502				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	9,586,922				30
	OTHER ASSETS					
31	Investments	7,011,073				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	384,191				34
35	Total other assets (sum of lines 31-34)	7,395,264				35
36	Total assets (sum of lines 11, 30 and 35)	23,646,497				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	298,809				37
38	Salaries, wages and fees payable	1,236,202				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	707,478				40
41	Deferred income	1,212,849				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	122,684				44
45	Total current liabilities (sum of lines 37 thru 44)	3,578,022				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	9,162,813				47
48	Unsecured loans					48
49	Other long term liabilities	1,683,022				49
50	Total long term liabilities (sum of lines 46 thru 49)	10,845,835				50
51	Total liabilities (sum of lines 45 and 50)	14,423,857				51
	CAPITAL ACCOUNTS					
52	General fund balance	9,222,640				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	9,222,640				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	23,646,497				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		9,734,221			1
2	Net income (loss) (from Worksheet G-3, line 29)		-511,581			2
3	Total (sum of line 1 and line 2)		9,222,640			3
4	Additions (credit adjustments) (specify)					4
5	RESTRICTED CONTRIBUTIONS					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		9,222,640			11
12	Deductions (debit adjustments) (specify)					12
13	RELEASED FROM RESTRICTION					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,222,640			19

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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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	1,213,185		1,213,185	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	455,072		455,072	5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	1,668,257		1,668,257	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)	1,668,257		1,668,257	17
18	Ancillary services	5,884,004	19,682,224	25,566,228	18
19	Outpatient services	443,061	4,634,484	5,077,545	19
20	Rural Health Clinic (RHC)		629,741	629,741	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		1,015,003	1,015,003	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,995,322	25,961,452	33,956,774	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		17,371,687	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		17,371,687	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	33,956,774	1
2	Less contractual allowances and discounts on patients' accounts	18,301,851	2
3	Net patient revenues (line 1 minus line 2)	15,654,923	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	17,371,687	4
5	Net income from service to patients (line 3 minus line 4)	-1,716,764	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	26,243	6
7	Income from investments	539,724	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	20,095	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	40,664	14
15	Revenue from rental of living quarters	305,401	15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	57,753	17
18	Revenue from sale of medical records and abstracts	1,086	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	5,736	22
23	Governmental appropriations		23
24	Other (GAIN ON INVESTMENTS - NET)		24
24.01	Other (OTHER INCOME)	229,442	24.01
24.02	Other (OTHER GAINS)	22,057	24.02
24.03	Other (GAIN ON SALE OF EQUIPMENT)	500	24.03
24.04	Other (GRANT INCOME)	44,250	24.04
24.05	Other (EHR REVENUE)	404,807	24.05
25	Total other income (sum of lines 6-24)	1,697,758	25
26	Total (line 5 plus line 25)	-19,006	26
27	Other expenses (LOSS ON INVESTMENTS - NET)	492,575	27
27.01	Other expenses (LOSS ON SWAP HEDGING)		27.01
28	Total other expenses (sum of line 27 and subscripts)	492,575	28
29	Net income (or loss) for the period (line 26 minus line 28)	-511,581	29

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-1331** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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
1.01	2008 BLDG & FIXT							1.01
1.02	RHC BLDG & FIXT							1.02
2	Cap Rel Costs-Mvble Equip							2
2.01	2008 MVBLE EQUIP							2.01
2.02	RHC MVBLE EQUIP							2.02
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients							73
73.01	CARDIAC REHABILITATION							73.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.02	INDEPENDENT LIVING							192.02
192.03	MEALS ON WHEELS							192.03
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

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

COMPONENT CCN: 14-8504

WORKSHEET M-1

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

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	368,805		368,805		368,805		368,805	1
2	Physician Assistant								2
3	Nurse Practitioner	59,793		59,793		59,793		59,793	3
4	Visiting Nurse								4
5	Other Nurse	58,643		58,643		58,643		58,643	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	487,241		487,241		487,241		487,241	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		18,055	18,055		18,055		18,055	11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)		18,055	18,055		18,055		18,055	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		9,035	9,035		9,035		9,035	15
16	Transportation (Health Care Staff)		7,878	7,878		7,878		7,878	16
17	Deperciation-Medical Equipment						-281	-281	17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		16,913	16,913		16,913	-281	16,632	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	487,241	34,968	522,209		522,209	-281	521,928	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		5,522	5,522		5,522		5,522	29
30	Administrative Costs	158,383	35,584	193,967		193,967		193,967	30
31	Total Facility Overhead (sum of lines 29 and 30)	158,383	41,106	199,489		199,489		199,489	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	645,624	76,074	721,698		721,698	-281	721,417	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.

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-8504** **WORKSHEET M-2**

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.08	3,937	4,200	4,536		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.46	1,811	2,100	966		3
4	Subtotal (sum of lines 1 through 3)	1.54	5,748		5,502	5,748	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.54	5,748			5,748	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	521,928	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	521,928	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	199,489	14
15	Parent provider overhead allocated to facility (see instructions)	465,441	15
16	Total overhead (sum of lines 14 and 15)	664,930	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	664,930	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	664,930	19
20	Total allowable cost of RHC/FQHC sservices(sum of lines 10 and 19)	1,186,858	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.

MARSHALL BROWNING HOSPITAL Provider CCN: 14-1331	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2014 To: 06/30/2015	Run Date: 11/24/2015 Run Time: 10:46 Version: 2015.10 (11/17/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-8504** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,186,858	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	5,151	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,181,707	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	5,748	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	5,748	6
7	Adjusted cost per visit (line 3 divided by line 6)	205.59	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	205.59	205.59	205.59	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	1,115	1,114		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	229,233	229,027		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		458,260		16
16.01	Total program charges (see instructions)(from contractor's records)		250,025		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)		350,707		16.04
16.05	Total program cost (see instructions)		350,707		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		19,876		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		46,030		19
20	Net Medicare cost excluding vaccines (see instructions)		350,707		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,679		21
22	Total reimbursable Program cost (line 20 plus line 21)		354,386		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		354,386		26
26.01	Sequestration adjustment (see instructions)		7,088		26.01
27	Interim payments		268,628		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		78,670		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		6,885		30

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

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-8504** **WORKSHEET M-4**

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	487,241	487,241	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000091	0.000000	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	44		3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,221		4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,265		5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	521,928	521,928	6
7	Total overhead (from Wkst. M-2, line 16)	664,930	664,930	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004340		8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,886		9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	5,151		10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	35		11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	147.17		12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	25		13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	3,679		14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		5,151	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		3,679	16

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

COMPONENT CCN: 14-8504

WORKSHEET M-5

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

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				268,628	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				268,628	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		78,670	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				347,298	

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.