WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 09/12/2016 Time: 09:05 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 WARNER HOSPITAL AND HEALTH SERVICES (14-1303) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 05/01/2015 and ending 04/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

`
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		264,201	93,001	46,782	5,472	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		22,067				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			45,576			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		286,268	138,577	46,782	5,472	200

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

According to the Paperwork Reduction Act of 1995, no persons are required to resopnd to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 05 / 01 / 2015	To: 04 / 30 / 2016	20
21	Type of control (see instructions)	12		21

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

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

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, 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 Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				71

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA **WORKSHEET S-2 PART I**

		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)			N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination 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:	115,989	11,090		118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

141	Name:	Contractor's Name:		Contractor's Number:		141
142	Street:	P.O. Box:				142
143	City:	State:	ZIP Code:			143
144	Are provider based physicians' costs included in Worksheet A?			Y		144
145	If costs for renal services are claimed on 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	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1,140,680			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 transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2014	09 / 30 / 2014	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A	08/15/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for 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.	Y	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/29/2016	Y	06/29/2016	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	Y		Y		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

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

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

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

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

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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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	17	6,888	13,538.00		420	2	570	1
2	HMO and other (see instructions)						89			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						32		32	5
6	Hospital Adults & Peds. Swing Bed NF								20	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		17	6,888	13,538.00		452	2	622	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)		17	6,888	13,538.00		452	2	622	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							8,898	26
27	Total (sum of lines 14-26)		17							27
28	Observation Bed Days							19	169	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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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)					122	2	178	1
2	HMO and other (see instructions)					23			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)		104.63			122	2	178	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		16.02						26
27	Total (sum of lines 14-26)		120.65						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

SNF SERVICES

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

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

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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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)	0.543124	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,498,087	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid		5
6	Medicaid charges	5,403,849	6
7	Medicaid cost (line 1 times line 6)	2,934,960	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.	436,873	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)	436,873	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	79,164	112,394	191,558	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	42,996	61,044	104,040	21
22	Partial payment by patients approved for charity care	9,760	24,568	34,328	22
23	Cost of charity care (line 21 minus line 22)	33,236	36,476	69,712	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)	983,789	26
27	Medicare bad debts for the entire hospital complex (see instructions)	120,069	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	863,720	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	469,107	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	538,819	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	975,692	31

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		367,701	367,701	72,827	440,528	-8,882	431,646	1
2	00200	Cap Rel Costs-Mvble Equip		731,463	731,463	9,793	741,256	-375,981	365,275	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		1,728,086	1,728,086		1,728,086	190,876	1,918,962	4
5	00500	Administrative & General	905,537	1,173,735	2,079,272	107,595	2,186,867	6,321	2,193,188	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	176,042	498,364	674,406		674,406		674,406	7
8	00800	Laundry & Linen Service	3,479	103,311	106,790		106,790		106,790	8
9	00900	Housekeeping	100,254	33,706	133,960		133,960		133,960	9
10	01000	Dietary	123,714	145,039	268,753	-54,407	214,346	-96,710	117,636	10
11	01100	Cafeteria				54,407	54,407	-25,700	28,707	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	177,976	4,858	182,834		182,834	-345	182,489	13
14	01400	Central Services & Supply	20,289	112,332	132,621	-111,486	21,135		21,135	14
15	01500	Pharmacy	131,542	577,623	709,165	-263,556	445,609	-58,711	386,898	15
16	01600	Medical Records & Library	142,688	71,932	214,620	8,550	223,170	-4,983	218,187	16
17	01700	Social Service	47,606	2,579	50,185		50,185		50,185	17
19	01900	Nonphysician Anesthetists				153,000	153,000		153,000	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	627,409	157,730	785,139	-43,223	741,916	-115,920	625,996	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	149,268	121,692	270,960		270,960	-90,580	180,380	50
53	05300	Anesthesiology		159,594	159,594	-153,000	6,594		6,594	53
54	05400	Radiology-Diagnostic	268,272	600,943	869,215		869,215	-353	868,862	54
60	06000	Laboratory	371,148	479,216	850,364	4,006	854,370		854,370	60
62	06200	Whole Blood & Packed Red Blood Cells				3,800	3,800		3,800	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	06400	Intravenous Therapy				69,340	69,340		69,340	64
65	06500	Respiratory Therapy	212,225	50,833	263,058	-22,263	240,795	-375	240,420	65
66	06600	Physical Therapy		472,791	472,791	-16,937	455,854	-9,353	446,501	66
69	06900	Electrocardiology	48,112	22,304	70,416		70,416	-25,439	44,977	69
71	07100	Medical Supplies Charged to Patients				133,749	133,749	-52	133,697	71
72	07200	Impl. Dev. Charged to Patients		89,714	89,714		89,714		89,714	72
73	07300	Drugs Charged to Patients				263,556	263,556	-5,499	258,057	73
76	03950	CARDIAC REHAB	61,072	2,742	63,814		63,814		63,814	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	1,003,088	226,141	1,229,229	-141,697	1,087,532	-18,413	1,069,119	88
90	09000	Clinic				6,925	6,925		6,925	90
90.01	09001	PROVIDER BASED CLINIC								90.01
91	09100	Emergency	541,987	959,522	1,501,509	-43,648	1,457,861		1,457,861	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		54,268	54,268	-54,268				113
118		SUBTOTALS (sum of lines 1-117)	5,111,708	8,948,219	14,059,927	-16,937	14,042,990	-640,099	13,402,891	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices	63,707	3,556	67,263		67,263		67,263	192
192.01	19201	LIFELINE								192.01
192.02	19202	HOME MEDICAL EQUIPMENT								192.02
192.03	19203	COMMUNITY BENEFIT				16,937	16,937		16,937	192.03
192.04	19204	RENTAL PROPERTIES								192.04
200		TOTAL (sum of lines 118-199)	5,175,415	8,951,775	14,127,190		14,127,190	-640,099	13,487,091	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COSTS FROM DIET	A	Cafeteria	11	25,045	29,362	1
500	Total reclassifications				25,045	29,362	500
	Code Letter - A						
1	TO RECLASS DRUGS SOLD TO PATIENTS	B	Drugs Charged to Patients	73		263,556	1
500	Total reclassifications					263,556	500
	Code Letter - B						
1	TO RECLASS INTEREST EXPENSE	C	Cap Rel Costs-Bldg & Fixt	1		54,268	1
500	Total reclassifications					54,268	500
	Code Letter - C						
1	TO RECLASS SUPPLIES CHARGED TO PTS	D	Medical Supplies Charged to P	71		111,486	1
500	Total reclassifications					111,486	500
	Code Letter - D						
1	TO RECLASS ER PHYSICIAN CONTRACTED	E	Administrative & General	5		7,206	1
500	Total reclassifications					7,206	500
	Code Letter - E						
1	TO RECLSS PROPERTY INS EXP	F	Other Cap Rel Costs	3		28,352	1
500	Total reclassifications					28,352	500
	Code Letter - F						
1	TO RECLASS RHC ADMIN EXPENSES	G	Administrative & General	5		50,970	1
500	Total reclassifications					50,970	500
	Code Letter - G						
1	TO RECLASS OXYGEN SUPPLIES	H	Medical Supplies Charged to P	71		22,263	1
500	Total reclassifications					22,263	500
	Code Letter - H						
1	TO RECLASS NURSING COST	I	Intravenous Therapy	64	69,340		1
2			Whole Blood & Packed Red Bloo	62	3,800		2
3			Clinic	90	6,925		3
500	Total reclassifications				80,065		500
	Code Letter - I						
1	TO RECLASS GRANT EXPENSES	J	Medical Records & Library	16		8,550	1
2			Rural Health Clinic	88		12,500	2
3			Emergency	91		400	3
500	Total reclassifications					21,450	500
	Code Letter - J						
1	TO RECLASS RHC PHYSICIAN ADMIN	K	Administrative & General	5	99,221		1
500	Total reclassifications				99,221		500
	Code Letter - K						
1	TO RECLASS ATHLETIC TRAINER COM BEN	L	COMMUNITY BENEFIT	192.03		16,937	1
500	Total reclassifications					16,937	500
	Code Letter - L						
1	TO RECLASS CRNA EXPENSE	M	Nonphysician Anesthetists	19		153,000	1
500	Total reclassifications					153,000	500
	Code Letter - M						
1	TO RECLASS RHC LAB TESTS	N	Laboratory	60		4,006	1
500	Total reclassifications					4,006	500
	Code Letter - N						
	GRAND TOTAL (Increases)				204,331	762,856	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS CAFETERIA COSTS FROM DIET	A	Dietary	10	25,045	29,362		1
500	Total reclassifications				25,045	29,362		500
	Code letter - A							
1	TO RECLASS DRUGS SOLD TO PATIENTS	B	Pharmacy	15		263,556		1
500	Total reclassifications					263,556		500
	Code letter - B							
1	TO RECLASS INTEREST EXPENSE	C	Interest Expense	113		54,268	11	1
500	Total reclassifications					54,268		500
	Code letter - C							
1	TO RECLASS SUPPLIES CHARGED TO PTS	D	Central Services & Supply	14		111,486		1
500	Total reclassifications					111,486		500
	Code letter - D							
1	TO RECLASS ER PHYSICIAN CONTRACTED	E	Emergency	91		7,206		1
500	Total reclassifications					7,206		500
	Code letter - E							
1	TO RECLSS PROPERTY INS EXP	F	Administrative & General	5		28,352	12	1
500	Total reclassifications					28,352		500
	Code letter - F							
1	TO RECLASS RHC ADMIN EXPENSES	G	Rural Health Clinic	88		50,970		1
500	Total reclassifications					50,970		500
	Code letter - G							
1	TO RECLASS OXYGEN SUPPLIES	H	Respiratory Therapy	65		22,263		1
500	Total reclassifications					22,263		500
	Code letter - H							
1	TO RECLASS NURSING COST	I	Adults & Pediatrics	30	43,223			1
2			Emergency	91	36,842			2
3								3
500	Total reclassifications				80,065			500
	Code letter - I							
1	TO RECLASS GRANT EXPENSES	J	Administrative & General	5		21,450		1
2								2
3								3
500	Total reclassifications					21,450		500
	Code letter - J							
1	TO RECLASS RHC PHYSICIAN ADMIN	K	Rural Health Clinic	88	99,221			1
500	Total reclassifications				99,221			500
	Code letter - K							
1	TO RECLASS ATHLETIC TRAINER COM BEN	L	Physical Therapy	66		16,937		1
500	Total reclassifications					16,937		500
	Code letter - L							
1	TO RECLASS CRNA EXPENSE	M	Anesthesiology	53		153,000		1
500	Total reclassifications					153,000		500
	Code letter - M							
1	TO RECLASS RHC LAB TESTS	N	Rural Health Clinic	88		4,006		1
500	Total reclassifications					4,006		500
	Code letter - N							
	GRAND TOTAL (Decreases)				204,331	762,856		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	343,588					343,588		1
2	Land Improvements								2
3	Buildings and Fixtures	10,726,380	52,959		52,959	3,845	10,775,494		3
4	Building Improvements								4
5	Fixed Equipment	125,772					125,772		5
6	Movable Equipment	4,651,951	738,780		738,780	631,214	4,759,517		6
7	HIT-designated Assets	1,056,607					1,056,607		7
8	Subtotal (sum of lines 1-7)	16,904,298	791,739		791,739	635,059	17,060,978		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	16,904,298	791,739		791,739	635,059	17,060,978		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	367,701						367,701	1
2	Cap Rel Costs-Mvble Equip	731,463						731,463	2
3	Total (sum of lines 1-2)	1,099,164						1,099,164	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	10,901,266		10,901,266	0.654589	18,559			18,559	1
2	Cap Rel Costs-Mvble Equ	5,752,341		5,752,341	0.345411	9,793			9,793	2
3	Total (sum of lines 1-2)	16,653,607		16,653,607	1.000000	28,352			28,352	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	367,701		45,386	18,559			431,646	1
2	Cap Rel Costs-Mvble Equip	355,482			9,793			365,275	2
3	Total (sum of lines 1-2)	723,183		45,386	28,352			796,921	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-8,882	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)	B	-3,325	Administrative & General	5	11	3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-247,193				10
11	Sale of scrap, waste, etc. (chapter 23)	B	-353	Radiology-Diagnostic	54		11
12	Related organization transactions (chapter 10)	Wkst A-8-1	61,578				12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-25,700	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-52	Medical Supplies Charged to Patients	71		16
17	Sale of drugs to other than patients	B	-5,499	Drugs Charged to Patients	73		17
18	Sale of medical records and abstracts	B	-4,983	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment	A	-347,673	Cap Rel Costs-Mvble Equip	2	9	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	OTHER INCOME	B	-7,387	Administrative & General	5		33
34	OUTSIDE DIETARY SERVICES	B	-96,710	Dietary	10		34
35							35
36	FITNESS MGMT	B	-8,130	Physical Therapy	66		36
37							37
38	EHR DEPRECIATION - CAPITAL LEASE	A	-24,996	Cap Rel Costs-Mvble Equip	2	9	38
39	OTHER REVENUE - RHC	B	-3,159	Rural Health Clinic	88		39
40	RESTING METABOLIC	B	-375	Respiratory Therapy	65		40
41	LOBBYING EXPENSE	A	-6,898	Administrative & General	5		41
42	ADVERTISING EXPENSE	A	-36,925	Administrative & General	5		42
43	MARKETING OTHER EXPENSE	A	-722	Administrative & General	5		43
44	CLINICAL TRAINING CLASSES	A	-345	Nursing Administration	13		44
45	PENSION DIFFERENTIAL	A	190,876	Employee Benefits Department	4		45
46	NON-ALLOW PURCH SVC - CABLE TV	A	-1,223	Physical Therapy	66		46
47	DEPRECIATION ON NON-ALLOW CABLE TV	A	-3,312	Cap Rel Costs-Mvble Equip	2	9	47
48	340B PROGRAM	A	-58,711	Pharmacy	15		48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-640,099				50

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

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

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	5	Administrative & General	ADMINISTRATION & GENERAL	61,578		61,578		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			61,578		61,578		5

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

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

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

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

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

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	60	Laboratory	2,147		2,147					1
2	69	Electrocardiology AGGREGATE	25,439	25,439						2
3	91	Emergency CORE	810,724		810,724					3
4	88	Rural Health Clinic AGGREGATE	411,326	15,254	396,072					4
5	50	Operating Room AGGREGATE	90,580	90,580						5
6	30	Adults & Pediatrics HOSPITALIST	115,920	115,920						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	1,456,136	247,193	1,208,943					200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	60	Laboratory								1
2	69	Electrocardiology AGGREGATE							25,439	2
3	91	Emergency CORE								3
4	88	Rural Health Clinic AGGREGATE							15,254	4
5	50	Operating Room AGGREGATE							90,580	5
6	30	Adults & Pediatrics HOSPITALIST							115,920	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							247,193	200

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					12	1
2	Line 1 multiplied by 15 hours per week					180	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					260	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.40	7
8	Optional travel expense rate					0.54	8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		12,274.00	5,713.00	1,364.00		9
10	AHSEA (see instructions)		78.66	59.00	13.78		10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	39.33	39.33	29.50			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)	965,473	15
16	Assistants (column 3, line 9 times column 3, line 10)	337,067	16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	1,302,540	17
18	Aides (column 4, line 9 times column 4, line 10)	18,796	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)	1,321,336	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)	1,321,336	23

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

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)	10,226	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)	10,226	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,404	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	11,630	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)	11,630	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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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)	1,321,336	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	11,630	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	1,332,966	63
64	Total cost of outside supplier services (from provider records)	266,279	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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)					2	1
2	Line 1 multiplied by 15 hours per week					30	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					3	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.40	7
8	Optional travel expense rate					0.54	8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		10.40				9
10	AHSEA (see instructions)		71.64				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)	35.82	35.82				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)	745	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)	745	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)	745	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)	71.63	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	2,149	22
23	Total salary equivalency (see instructions)	2,149	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)	107	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)	107	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	16	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	123	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)	123	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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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)	2,149	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	123	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)	2,272	63
64	Total cost of outside supplier services (from provider records)	528	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINIS-TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	431,646	431,646					1
2	Cap Rel Costs-Mvble Equip	365,275		365,275				2
4	Employee Benefits Department	1,918,962	2,591	2,192	1,923,745			4
5	Administrative & General	2,193,188	47,165	39,912	373,479	2,653,744	2,653,744	5
6	Maintenance & Repairs							6
7	Operation of Plant	674,406	83,942	71,035	65,436	894,819	219,196	7
8	Laundry & Linen Service	106,790	5,113	4,327	1,293	117,523	28,789	8
9	Housekeeping	133,960	2,535	2,145	37,265	175,905	43,090	9
10	Dietary	117,636	13,375	11,318	36,676	179,005	43,849	10
11	Cafeteria	28,707			9,309	38,016	9,312	11
12	Maintenance of Personnel							12
13	Nursing Administration	182,489	3,657	3,094	66,155	255,395	62,562	13
14	Central Services & Supply	21,135	8,720	7,379	7,542	44,776	10,968	14
15	Pharmacy	386,898	7,437	6,294	48,895	449,524	110,116	15
16	Medical Records & Library	218,187	9,631	8,150	53,038	289,006	70,795	16
17	Social Service	50,185			17,696	67,881	16,628	17
19	Nonphysician Anesthetists	153,000				153,000	37,479	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	625,996	50,896	43,070	218,559	938,521	229,901	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	180,380	29,749	25,175	55,484	290,788	71,232	50
53	Anesthesiology	6,594	1,109	939		8,642	2,117	53
54	Radiology-Diagnostic	868,862	29,947	25,343	99,719	1,023,871	250,808	54
60	Laboratory	854,370	10,375	8,780	137,959	1,011,484	247,774	60
62	Whole Blood & Packed Red Blood Cells	3,800			1,412	5,212	1,277	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	69,340			25,774	95,114	23,299	64
65	Respiratory Therapy	240,420	2,547	2,156	78,886	324,009	79,370	65
66	Physical Therapy	446,501	15,575	13,180		475,256	116,419	66
69	Electrocardiology	44,977	1,525	1,290	17,884	65,676	16,088	69
71	Medical Supplies Charged to Patients	133,697				133,697	32,751	71
72	Impl. Dev. Charged to Patients	89,714				89,714	21,976	72
73	Drugs Charged to Patients	258,057				258,057	63,214	73
76	CARDIAC REHAB	63,814	1,983	1,678	22,701	90,176	22,090	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,069,119	53,207	45,026	335,975	1,503,327	368,256	88
90	Clinic	6,925			2,574	9,499	2,327	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	1,457,861	22,250	18,829	186,354	1,685,294	412,828	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	13,402,891	403,329	341,312	1,900,065	13,326,931	2,614,511	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	67,263	28,317	23,963	23,680	143,223	35,084	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT	16,937				16,937	4,149	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	13,487,091	431,646	365,275	1,923,745	13,487,091	2,653,744	202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	1,114,015						7
8	Laundry & Linen Service	19,118	165,430					8
9	Housekeeping	9,478		228,473				9
10	Dietary	50,007		10,526	283,387			10
11	Cafeteria					47,328		11
12	Maintenance of Personnel							12
13	Nursing Administration	13,672		2,878		2,236	336,743	13
14	Central Services & Supply	32,604		6,863		255		14
15	Pharmacy	27,808		5,853		1,653		15
16	Medical Records & Library	36,011		7,580		1,793		16
17	Social Service					598	10,772	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	190,296	165,430	40,056	283,387	7,339	143,837	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	111,230		23,413		1,875	20,554	50
53	Anesthesiology	4,148		873				53
54	Radiology-Diagnostic	111,972		23,569		3,370		54
60	Laboratory	38,791		8,165		4,663		60
62	Whole Blood & Packed Red Blood Cells					48		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					871		64
65	Respiratory Therapy	9,524		2,005		2,666		65
66	Physical Therapy	58,234		12,258				66
69	Electrocardiology	5,701		1,200		604		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	7,415		1,561		767	13,821	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	198,938		41,876		11,357	31,409	88
90	Clinic					87		90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	83,191		17,511		6,346	116,350	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,008,138	165,430	206,187	283,387	46,528	336,743	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	105,877		22,286		800		192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,114,015	165,430	228,473	283,387	47,328	336,743	202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	
		14	15	16	17	19	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	95,466						14
15	Pharmacy	627	595,581					15
16	Medical Records & Library	6		405,191				16
17	Social Service				95,879			17
19	Nonphysician Anesthetists					190,479		19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,508		13,924	95,879		2,112,078	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,556		13,707			535,355	50
53	Anesthesiology	70		7,298		190,479	213,627	53
54	Radiology-Diagnostic	8,466		94,909			1,516,965	54
60	Laboratory	28,726		71,631			1,411,234	60
62	Whole Blood & Packed Red Blood Cells			645			7,182	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			18,473			137,757	64
65	Respiratory Therapy	710		7,913			426,197	65
66	Physical Therapy	1,251		44,264			707,682	66
69	Electrocardiology	263		7,898			97,430	69
71	Medical Supplies Charged to Patients	22,956		7,224			196,628	71
72	Impl. Dev. Charged to Patients	18,473		2,447			132,610	72
73	Drugs Charged to Patients		595,581	25,048			941,900	73
76	CARDIAC REHAB	217		3,167			139,214	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,693		30,683			2,187,539	88
90	Clinic	165		824			12,902	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	5,779		55,136			2,382,435	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	95,466	595,581	405,191	95,879	190,479	13,158,735	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						307,270	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						21,086	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	95,466	595,581	405,191	95,879	190,479	13,487,091	202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,112,078					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		535,355					50
53	Anesthesiology		213,627					53
54	Radiology-Diagnostic		1,516,965					54
60	Laboratory		1,411,234					60
62	Whole Blood & Packed Red Blood Cells		7,182					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		137,757					64
65	Respiratory Therapy		426,197					65
66	Physical Therapy		707,682					66
69	Electrocardiology		97,430					69
71	Medical Supplies Charged to Patients		196,628					71
72	Impl. Dev. Charged to Patients		132,610					72
73	Drugs Charged to Patients		941,900					73
76	CARDIAC REHAB		139,214					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		2,187,539					88
90	Clinic		12,902					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		2,382,435					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		13,158,735					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		307,270					192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT		21,086					192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		13,487,091					202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINIS-TRATIVE & GENERAL	
		0	1	2	2A	4	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		2,591	2,192	4,783	4,783		4
5	Administrative & General		47,165	39,912	87,077	930	88,007	5
6	Maintenance & Repairs							6
7	Operation of Plant		83,942	71,035	154,977	163	7,270	7
8	Laundry & Linen Service		5,113	4,327	9,440	3	955	8
9	Housekeeping		2,535	2,145	4,680	93	1,429	9
10	Dietary		13,375	11,318	24,693	91	1,454	10
11	Cafeteria					23	309	11
12	Maintenance of Personnel							12
13	Nursing Administration		3,657	3,094	6,751	164	2,075	13
14	Central Services & Supply		8,720	7,379	16,099	19	364	14
15	Pharmacy		7,437	6,294	13,731	122	3,652	15
16	Medical Records & Library		9,631	8,150	17,781	132	2,348	16
17	Social Service					44	551	17
19	Nonphysician Anesthetists						1,243	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		50,896	43,070	93,966	543	7,625	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		29,749	25,175	54,924	138	2,362	50
53	Anesthesiology		1,109	939	2,048		70	53
54	Radiology-Diagnostic		29,947	25,343	55,290	248	8,318	54
60	Laboratory		10,375	8,780	19,155	343	8,217	60
62	Whole Blood & Packed Red Blood Cells					4	42	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					64	773	64
65	Respiratory Therapy		2,547	2,156	4,703	196	2,632	65
66	Physical Therapy		15,575	13,180	28,755		3,861	66
69	Electrocardiology		1,525	1,290	2,815	44	534	69
71	Medical Supplies Charged to Patients						1,086	71
72	Impl. Dev. Charged to Patients						729	72
73	Drugs Charged to Patients						2,096	73
76	CARDIAC REHAB		1,983	1,678	3,661	56	733	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		53,207	45,026	98,233	835	12,213	88
90	Clinic					6	77	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		22,250	18,829	41,079	463	13,687	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		403,329	341,312	744,641	4,724	86,705	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		28,317	23,963	52,280	59	1,164	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						138	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		431,646	365,275	796,921	4,783	88,007	202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	162,410						7
8	Laundry & Linen Service	2,787	13,185					8
9	Housekeeping	1,382		7,584				9
10	Dietary	7,290		349	33,877			10
11	Cafeteria					332		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,993		96		16	11,095	13
14	Central Services & Supply	4,753		228		2		14
15	Pharmacy	4,054		194		12		15
16	Medical Records & Library	5,250		252		13		16
17	Social Service					4	355	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	27,743	13,185	1,330	33,877	51	4,739	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	16,216		777		13	677	50
53	Anesthesiology	605		29				53
54	Radiology-Diagnostic	16,324		782		24		54
60	Laboratory	5,655		271		33		60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy					6		64
65	Respiratory Therapy	1,388		67		19		65
66	Physical Therapy	8,490		407				66
69	Electrocardiology	831		40		4		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	1,081		52		5	455	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	29,004		1,389		79	1,035	88
90	Clinic					1		90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	12,128		581		44	3,834	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	146,974	13,185	6,844	33,877	326	11,095	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	15,436		740		6		192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	162,410	13,185	7,584	33,877	332	11,095	202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS + LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	
		14	15	16	17	19	24	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	21,465						14
15	Pharmacy	141	21,906					15
16	Medical Records & Library	1		25,777				16
17	Social Service				954			17
19	Nonphysician Anesthetists					1,243		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	789		886	954		185,688	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	575		872			76,554	50
53	Anesthesiology	16		464			3,232	53
54	Radiology-Diagnostic	1,903		6,037			88,926	54
60	Laboratory	6,458		4,557			44,689	60
62	Whole Blood & Packed Red Blood Cells			41			87	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			1,175			2,018	64
65	Respiratory Therapy	160		503			9,668	65
66	Physical Therapy	281		2,816			44,610	66
69	Electrocardiology	59		502			4,829	69
71	Medical Supplies Charged to Patients	5,162		460			6,708	71
72	Impl. Dev. Charged to Patients	4,154		156			5,039	72
73	Drugs Charged to Patients		21,906	1,594			25,596	73
76	CARDIAC REHAB	49		202			6,294	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	381		1,952			145,121	88
90	Clinic	37		52			173	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	1,299		3,508			76,623	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	21,465	21,906	25,777	954		725,855	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices						69,685	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT						138	192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments					1,243	1,243	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,465	21,906	25,777	954	1,243	796,921	202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL					
		25	26					
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		185,688					30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		76,554					50
53	Anesthesiology		3,232					53
54	Radiology-Diagnostic		88,926					54
60	Laboratory		44,689					60
62	Whole Blood & Packed Red Blood Cells		87					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		2,018					64
65	Respiratory Therapy		9,668					65
66	Physical Therapy		44,610					66
69	Electrocardiology		4,829					69
71	Medical Supplies Charged to Patients		6,708					71
72	Impl. Dev. Charged to Patients		5,039					72
73	Drugs Charged to Patients		25,596					73
76	CARDIAC REHAB		6,294					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		145,121					88
90	Clinic		173					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		76,623					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		725,855					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		69,685					192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT		138					192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross Foot Adjustments		1,243					200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		796,921					202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINIS-TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	69,646						1
2	Cap Rel Costs-Mvble Equip		69,646					2
4	Employee Benefits Department	418	418	5,175,415				4
5	Administrative & General	7,610	7,610	1,004,758	-2,653,744	10,833,347		5
6	Maintenance & Repairs							6
7	Operation of Plant	13,544	13,544	176,042		894,819	48,074	7
8	Laundry & Linen Service	825	825	3,479		117,523	825	8
9	Housekeeping	409	409	100,254		175,905	409	9
10	Dietary	2,158	2,158	98,669		179,005	2,158	10
11	Cafeteria			25,045		38,016		11
12	Maintenance of Personnel							12
13	Nursing Administration	590	590	177,976		255,395	590	13
14	Central Services & Supply	1,407	1,407	20,289		44,776	1,407	14
15	Pharmacy	1,200	1,200	131,542		449,524	1,200	15
16	Medical Records & Library	1,554	1,554	142,688		289,006	1,554	16
17	Social Service			47,606		67,881		17
19	Nonphysician Anesthetists					153,000		19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,212	8,212	587,986		938,521	8,212	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,800	4,800	149,268		290,788	4,800	50
53	Anesthesiology	179	179			8,642	179	53
54	Radiology-Diagnostic	4,832	4,832	268,272		1,023,871	4,832	54
60	Laboratory	1,674	1,674	371,148		1,011,484	1,674	60
62	Whole Blood & Packed Red Blood Cells			3,800		5,212		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy			69,340		95,114		64
65	Respiratory Therapy	411	411	212,225		324,009	411	65
66	Physical Therapy	2,513	2,513			475,256	2,513	66
69	Electrocardiology	246	246	48,112		65,676	246	69
71	Medical Supplies Charged to Patients					133,697		71
72	Impl. Dev. Charged to Patients					89,714		72
73	Drugs Charged to Patients					258,057		73
76	CARDIAC REHAB	320	320	61,072		90,176	320	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	8,585	8,585	903,867		1,503,327	8,585	88
90	Clinic			6,925		9,499		90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	3,590	3,590	501,345		1,685,294	3,590	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	65,077	65,077	5,111,708	-2,653,744	10,673,187	43,505	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	4,569	4,569	63,707		143,223	4,569	192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT					16,937		192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	431,646	365,275	1,923,745		2,653,744	1,114,015	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.197714	5.244738	0.371708		0.244961	23.172921	203
204	Cost to be allocated (Per Wkst. B, Part II)			4,783		88,007	162,410	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000924		0.008124	3.378333	205

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE PATIENT DAYS	HOUSE-KEEPING SQUARE FEET	DIETARY PATIENT DAYS	CAFETERIA GROSS SALARIES	NURSING ADMINIS-TRATION DIRECT NRSG SALAR	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	570						8
9	Housekeeping		46,840					9
10	Dietary		2,158	570				10
11	Cafeteria				3,767,168			11
12	Maintenance of Personnel							12
13	Nursing Administration		590		177,976	1,513,063		13
14	Central Services & Supply		1,407		20,289		463,626	14
15	Pharmacy		1,200		131,542		3,044	15
16	Medical Records & Library		1,554		142,688		30	16
17	Social Service				47,606	48,403		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	570	8,212	570	584,186	646,290	17,038	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		4,800		149,268	92,356	12,414	50
53	Anesthesiology		179				342	53
54	Radiology-Diagnostic		4,832		268,272		41,113	54
60	Laboratory		1,674		371,148		139,509	60
62	Whole Blood & Packed Red Blood Cells				3,800			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy				69,340			64
65	Respiratory Therapy		411		212,225		3,446	65
66	Physical Therapy		2,513				6,075	66
69	Electrocardiology		246		48,112		1,277	69
71	Medical Supplies Charged to Patients						111,486	71
72	Impl. Dev. Charged to Patients						89,714	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB		320		61,072	62,099	1,054	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		8,585		903,867	141,126	8,220	88
90	Clinic				6,925		799	90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		3,590		505,145	522,789	28,065	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	570	42,271	570	3,703,461	1,513,063	463,626	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		4,569		63,707			192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	165,430	228,473	283,387	47,328	336,743	95,466	202
203	Unit Cost Multiplier (Wkst. B, Part I)	290.228070	4.877733	497.170175	0.012563	0.222557	0.205912	203
204	Cost to be allocated (Per Wkst. B, Part II)	13,185	7,584	33,877	332	11,095	21,465	204
205	Unit Cost Multiplier (Wkst. B, Part II)	23.131579	0.161913	59.433333	0.000088	0.007333	0.046298	205

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

	COST CENTER DESCRIPTIONS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS + LIBRARY GROSS REVENUE	SOCIAL SERVICE PATIENT DAYS	NONPHYSIC. ANESTHET. ASSIGNED TIME			
		15	16	17	19			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	518,911						15
16	Medical Records & Library		24,227,857					16
17	Social Service			570				17
19	Nonphysician Anesthetists				100			19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		832,556	570				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		819,577					50
53	Anesthesiology		436,355		100			53
54	Radiology-Diagnostic		5,674,879					54
60	Laboratory		4,283,106					60
62	Whole Blood & Packed Red Blood Cells		38,541					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy		1,104,606					64
65	Respiratory Therapy		473,169					65
66	Physical Therapy		2,646,733					66
69	Electrocardiology		472,226					69
71	Medical Supplies Charged to Patients		431,964					71
72	Impl. Dev. Charged to Patients		146,304					72
73	Drugs Charged to Patients	518,911	1,497,702					73
76	CARDIAC REHAB		189,386					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		1,834,694					88
90	Clinic		49,241					90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency		3,296,818					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	518,911	24,227,857	570	100			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
192.01	LIFELINE							192.01
192.02	HOME MEDICAL EQUIPMENT							192.02
192.03	COMMUNITY BENEFIT							192.03
192.04	RENTAL PROPERTIES							192.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	595,581	405,191	95,879	190,479			202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.147752	0.016724	168.208772	1,904.790000			203
204	Cost to be allocated (Per Wkst. B, Part II)	21,906	25,777	954	1,243			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.042215	0.001064	1.673684	12.430000			205

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,112,078		2,112,078			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	535,355		535,355			50
53	Anesthesiology	213,627		213,627			53
54	Radiology-Diagnostic	1,516,965		1,516,965			54
60	Laboratory	1,411,234		1,411,234			60
62	Whole Blood & Packed Red Blood Cells	7,182		7,182			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	137,757		137,757			64
65	Respiratory Therapy	426,197		426,197			65
66	Physical Therapy	707,682		707,682			66
69	Electrocardiology	97,430		97,430			69
71	Medical Supplies Charged to Patients	196,628		196,628			71
72	Impl. Dev. Charged to Patients	132,610		132,610			72
73	Drugs Charged to Patients	941,900		941,900			73
76	CARDIAC REHAB	139,214		139,214			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	2,187,539		2,187,539			88
90	Clinic	12,902		12,902			90
90.01	PROVIDER BASED CLINIC						90.01
91	Emergency	2,382,435		2,382,435			91
92	Observation Beds (Non-Distinct Part)	462,414		462,414			92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	13,621,149		13,621,149			200
201	Less Observation Beds	462,414		462,414			201
202	Total (line 200 minus line 201)	13,158,735		13,158,735			202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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	629,760		629,760				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	36,016	783,561	819,577	0.653209			50
53	Anesthesiology	21,055	415,300	436,355	0.489572			53
54	Radiology-Diagnostic	475,462	5,199,417	5,674,879	0.267312			54
60	Laboratory	422,599	3,860,507	4,283,106	0.329488			60
62	Whole Blood & Packed Red Blood Cells	672	37,869	38,541	0.186347			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy	108,955	995,651	1,104,606	0.124711			64
65	Respiratory Therapy	207,777	265,392	473,169	0.900729			65
66	Physical Therapy	26,545	2,620,188	2,646,733	0.267379			66
69	Electrocardiology	70,505	401,721	472,226	0.206321			69
71	Medical Supplies Charged to Patients	151,897	280,067	431,964	0.455195			71
72	Impl. Dev. Charged to Patients	8,704	137,600	146,304	0.906400			72
73	Drugs Charged to Patients	322,716	1,174,986	1,497,702	0.628897			73
76	CARDIAC REHAB		189,386	189,386	0.735081			76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	77,359	1,757,335	1,834,694				88
90	Clinic		49,241	49,241	0.262017			90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency	156,117	3,140,701	3,296,818	0.722647			91
92	Observation Beds (Non-Distinct Part)	21,347	181,449	202,796	2.280193			92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	2,737,486	21,490,371	24,227,857				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	2,737,486	21,490,371	24,227,857				202

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/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	0.653209		202,427			132,227		50
53	Anesthesiology	0.489572		112,110			54,886		53
54	Radiology-Diagnostic	0.267312		1,815,594			485,330		54
60	Laboratory	0.329488		1,509,581			497,389		60
62	Whole Blood & Packed Red Blood	0.186347		27,507			5,126		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124711		505,876			63,088		64
65	Respiratory Therapy	0.900729		73,871			66,538		65
66	Physical Therapy	0.267379		532,994			142,511		66
69	Electrocardiology	0.206321		175,095			36,126		69
71	Medical Supplies Charged to Pat	0.455195		84,234			38,343		71
72	Impl. Dev. Charged to Patients	0.906400		3,728			3,379		72
73	Drugs Charged to Patients	0.628897		643,342			404,596		73
76	CARDIAC REHAB	0.735081		104,984			77,172		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.262017		40,930			10,724		90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.722647		805,192			581,870		91
92	Observation Beds (Non-Distinct	2.280193		114,014			259,974		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			6,751,479			2,859,279		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			6,751,479			2,859,279		202

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/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	0.653209							50
53	Anesthesiology	0.489572							53
54	Radiology-Diagnostic	0.267312							54
60	Laboratory	0.329488							60
62	Whole Blood & Packed Red Blood	0.186347							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124711							64
65	Respiratory Therapy	0.900729							65
66	Physical Therapy	0.267379							66
69	Electrocardiology	0.206321							69
71	Medical Supplies Charged to Pat	0.455195							71
72	Impl. Dev. Charged to Patients	0.906400							72
73	Drugs Charged to Patients	0.628897							73
76	CARDIAC REHAB	0.735081							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.262017							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.722647							91
92	Observation Beds (Non-Distinct	2.280193							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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	185,688	7,916	177,772	739	240.56	2	481	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)	185,688		177,772	739		2	481	200

(A) Worksheet A line numbers

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

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26) 1	Total Charges (from Wkst. C, Part I, (col. 8) 2	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3	Inpatient Program Charges 4	Capital Costs (col. 3 x col. 4) 5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	76,554	819,577	0.093407			50
53	Anesthesiology	3,232	436,355	0.007407			53
54	Radiology-Diagnostic	88,926	5,674,879	0.015670			54
60	Laboratory	44,689	4,283,106	0.010434			60
62	Whole Blood & Packed Red Blood	87	38,541	0.002257			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
64	Intravenous Therapy	2,018	1,104,606	0.001827			64
65	Respiratory Therapy	9,668	473,169	0.020432			65
66	Physical Therapy	44,610	2,646,733	0.016855			66
69	Electrocardiology	4,829	472,226	0.010226			69
71	Medical Supplies Charged to Pat	6,708	431,964	0.015529			71
72	Impl. Dev. Charged to Patients	5,039	146,304	0.034442			72
73	Drugs Charged to Patients	25,596	1,497,702	0.017090			73
76	CARDIAC REHAB	6,294	189,386	0.033234			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	145,121	1,834,694	0.079098			88
90	Clinic	173	49,241	0.003513			90
90.01	PROVIDER BASED CLINIC						90.01
91	Emergency	76,623	3,296,818	0.023242			91
92	Observation Beds (Non-Distinct	40,654	202,796	0.200467			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	580,821	23,598,097				200

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	739		2		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)	739		2		200

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [XX] 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	190,479				190,479		53
54	Radiology-Diagnostic							54
60	Laboratory							60
62	Whole Blood & Packed Red Blood							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
64	Intravenous Therapy							64
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	PROVIDER BASED CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	190,479				190,479		200

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	819,577							50
53	Anesthesiology	436,355	0.436523						53
54	Radiology-Diagnostic	5,674,879							54
60	Laboratory	4,283,106							60
62	Whole Blood & Packed Red Blood	38,541							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	1,104,606							64
65	Respiratory Therapy	473,169							65
66	Physical Therapy	2,646,733							66
69	Electrocardiology	472,226							69
71	Medical Supplies Charged to Pat	431,964							71
72	Impl. Dev. Charged to Patients	146,304							72
73	Drugs Charged to Patients	1,497,702							73
76	CARDIAC REHAB	189,386							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,834,694							88
90	Clinic	49,241							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	3,296,818							91
92	Observation Beds (Non-Distinct	202,796							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	23,598,097							200

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/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	0.653209							50
53	Anesthesiology	0.489572							53
54	Radiology-Diagnostic	0.267312							54
60	Laboratory	0.329488							60
62	Whole Blood & Packed Red Blood	0.186347							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
64	Intravenous Therapy	0.124711							64
65	Respiratory Therapy	0.900729							65
66	Physical Therapy	0.267379							66
69	Electrocardiology	0.206321							69
71	Medical Supplies Charged to Pat	0.455195							71
72	Impl. Dev. Charged to Patients	0.906400							72
73	Drugs Charged to Patients	0.628897							73
76	CARDIAC REHAB	0.735081							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.262017							90
90.01	PROVIDER BASED CLINIC								90.01
91	Emergency	0.722647							91
92	Observation Beds (Non-Distinct	2.280193							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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes:	[ ] Title V - I/P	[XX] Hospital	[ ] SUB (Other)	[ ] ICF/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)	791	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	739	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)	570	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	21	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)	11	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	13	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)	7	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	420	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)	21	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	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,112,078	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)	1,568	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	918	25
26	Total swing-bed cost (see instructions)	90,044	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,022,034	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)	2,022,034	37

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	2,736.18	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,149,196	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)	1,149,196	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)	432,970	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	1,582,166	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)	57,460	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	30,098	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	87,558	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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/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)					169	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,736.18	88
89	Observation bed cost (line 87 x line 88) (see instructions)					462,414	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	185,688	2,112,078	0.087917	462,414	40,654	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	791	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	739	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)	570	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	21	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)	11	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	13	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)	7	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,112,078	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)	1,568	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	918	25
26	Total swing-bed cost (see instructions)	90,044	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,022,034	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)	2,022,034	37

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	2,736.18	38
39	Program general inpatient routine service cost (line 9 x line 38)	5,472	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)	5,472	41

		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	5,472	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	481	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)	481	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					169	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/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		436,798		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.653209	2,444	1,596	50
53	Anesthesiology	0.489572	1,659	812	53
54	Radiology-Diagnostic	0.267312	201,961	53,987	54
60	Laboratory	0.329488	188,509	62,111	60
62	Whole Blood & Packed Red Blood Cells	0.186347			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124711	12,804	1,597	64
65	Respiratory Therapy	0.900729	140,937	126,946	65
66	Physical Therapy	0.267379	13,107	3,505	66
69	Electrocardiology	0.206321	31,820	6,565	69
71	Medical Supplies Charged to Patients	0.455195	104,747	47,680	71
72	Impl. Dev. Charged to Patients	0.906400			72
73	Drugs Charged to Patients	0.628897	201,425	126,676	73
76	CARDIAC REHAB	0.735081			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.262017			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.722647	883	638	91
92	Observation Beds (Non-Distinct Part)	2.280193	376	857	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		900,672	432,970	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		900,672		202

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes:
[ ] Title V [ ] Hospital [ ] SUB (Other] [XX] Swing Bed SNF [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] Swing Bed NF [ ] TEFRA
[ ] Title XIX [ ] IRF [ ] NF [ ] ICF/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	0.653209			50
53	Anesthesiology	0.489572			53
54	Radiology-Diagnostic	0.267312	930	249	54
60	Laboratory	0.329488	3,525	1,161	60
62	Whole Blood & Packed Red Blood Cells	0.186347			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124711			64
65	Respiratory Therapy	0.900729	9,820	8,845	65
66	Physical Therapy	0.267379	5,724	1,530	66
69	Electrocardiology	0.206321	802	165	69
71	Medical Supplies Charged to Patients	0.455195	3,471	1,580	71
72	Impl. Dev. Charged to Patients	0.906400			72
73	Drugs Charged to Patients	0.628897	23,000	14,465	73
76	CARDIAC REHAB	0.735081			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.262017			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.722647			91
92	Observation Beds (Non-Distinct Part)	2.280193			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		47,272	27,995	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		47,272		202

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/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	0.653209			50
53	Anesthesiology	0.489572			53
54	Radiology-Diagnostic	0.267312			54
60	Laboratory	0.329488			60
62	Whole Blood & Packed Red Blood Cells	0.186347			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
64	Intravenous Therapy	0.124711			64
65	Respiratory Therapy	0.900729			65
66	Physical Therapy	0.267379			66
69	Electrocardiology	0.206321			69
71	Medical Supplies Charged to Patients	0.455195			71
72	Impl. Dev. Charged to Patients	0.906400			72
73	Drugs Charged to Patients	0.628897			73
76	CARDIAC REHAB	0.735081			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.262017			90
90.01	PROVIDER BASED CLINIC				90.01
91	Emergency	0.722647			91
92	Observation Beds (Non-Distinct Part)	2.280193			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	2,859,279			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)	2,859,279			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)	2,887,872			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)	14,029			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,057,108			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)	1,816,735			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)	1,816,735			30
31	Primary payer payments	795			31
32	Subtotal (line 30 minus line 31)	1,815,940			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)	134,682			34
35	Adjusted reimbursable bad debts (see instructions)	87,543			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	134,682			36
37	Subtotal (see instructions)	1,903,483			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)	1,903,483			40
40.01	Sequestration adjustment (see instructions)	38,070			40.01
41	Interim payments	1,772,412			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	93,001			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,098,788		1,711,966	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	12/07/2015	16,138	12/07/2015	41,962	3.01
	amount based on subsequent revision of the interim		.02	05/07/2016	82,203	05/07/2016	18,484	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		98,341		60,446	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)				1,197,129		1,772,412	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		264,201		93,001	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				1,461,330		1,865,413	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.

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				78,564			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	05/04/2016	13,744			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		13,744			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)				92,308			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		22,067			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				114,375			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.

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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)	178	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	420	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	89	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	570	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	24,227,857	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	191,558	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1,140,680	7
8	Calculation of the HIT incentive payment (see instructions)	1,140,680	8
9	Sequestration adjustment amount (see instructions)	22,814	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1,117,866	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	1,071,084	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	46,782	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.

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	88,434		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)	28,275		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	32		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)	116,709		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	116,709		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	116,709		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			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)	116,709		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)	116,709		19
19.01	Sequestration adjustment (see instructions)	2,334		19.01
20	Interim payments	92,308		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	22,067		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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

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

1	Inpatient services	1,582,166	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,582,166	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,597,988	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)	1,597,988	19
20	Deductibles (exclude professional component)	126,028	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,471,960	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,471,960	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	29,527	25
26	Adjusted reimbursable bad debts (see instructions)	19,193	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,527	27
28	Subtotal (sum of lines 24 and 26)	1,491,153	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,491,153	30
30.01	Sequestration adjustment (see instructions)	29,823	30.01
31	Interim payments	1,197,129	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	264,201	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	5,472		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	5,472		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	5,472		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	5,472		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)	5,472		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)	5,472		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)	5,472		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	5,472		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)	5,472		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	5,472		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	2,578,006				1
2	Temporary investments	4,617,921				2
3	Notes receivable					3
4	Accounts receivable	4,021,572				4
5	Other receivables	256,798				5
6	Allowances for uncollectible notes and accounts receivable	-2,106,154				6
7	Inventory	291,172				7
8	Prepaid expenses	137,974				8
9	Other current assets	33,445				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	9,830,734				11
	FIXED ASSETS					
12	Land	343,588				12
13	Land improvements					13
14	Accumulated depreciation					14
15	Buildings	10,775,495				15
16	Accumulated depreciation	-7,725,468				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	125,772				19
20	Accumulated depreciation	-75,059				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	4,759,516				23
24	Accumulated depreciation	-3,681,907				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,056,607				27
28	Accumulated depreciation	-695,346				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	4,883,198				30
	OTHER ASSETS					
31	Investments	1,078,720				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	808,977				34
35	Total other assets (sum of lines 31-34)	1,887,697				35
36	Total assets (sum of lines 11, 30 and 35)	16,601,629				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	551,701				37
38	Salaries, wages and fees payable	560,527				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	279,065				40
41	Deferred income	6,436				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	41,416				44
45	Total current liabilities (sum of lines 37 thru 44)	1,439,145				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	772,579				47
48	Unsecured loans					48
49	Other long term liabilities	3,499,031				49
50	Total long term liabilities (sum of lines 46 thru 49)	4,271,610				50
51	Total liabilities (sum of lines 45 and 50)	5,710,755				51
	CAPITAL ACCOUNTS					
52	General fund balance	10,890,874				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	10,890,874				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	16,601,629				60

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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		10,110,362			1
2	Net income (loss) (from Worksheet G-3, line 29)		3,665,869			2
3	Total (sum of line 1 and line 2)		13,776,231			3
4	Additions (credit adjustments) (specify)					4
5	CAPITAL GRANTS					5
6	UNREALIZED GAIN					6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		13,776,231			11
12	Deductions (debit adjustments) (specify)					12
13	UNREALIZED LOSS	306				13
14	PRIOR PERIOD ADJUSTMENT	2,885,051				14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		2,885,357			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,890,874			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5	CAPITAL GRANTS					5
6	UNREALIZED GAIN					6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13	UNREALIZED LOSS					13
14	PRIOR PERIOD ADJUSTMENT					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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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	758,814		758,814	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	758,814		758,814	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)	758,814		758,814	17
18	Ancillary services	1,990,222		1,990,222	18
19	Outpatient services		19,901,666	19,901,666	19
20	Rural Health Clinic (RHC)	77,359	1,757,335	1,834,694	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	2,826,395	21,659,001	24,485,396	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		14,127,190	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38	INTEREST EXPENSE	-54,268		38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-54,268	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		14,072,922	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	24,485,396	1
2	Less contractual allowances and discounts on patients' accounts	9,963,979	2
3	Net patient revenues (line 1 minus line 2)	14,521,417	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	14,072,922	4
5	Net income from service to patients (line 3 minus line 4)	448,495	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	2,259,234	6
7	Income from investments	13,604	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	25,700	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients	52	16
17	Revenue from sale of drugs to other than patients	5,499	17
18	Revenue from sale of medical records and abstracts	8,142	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines	1,156	21
22	Rental of hosptial space	31,556	22
23	Governmental appropriations	254,641	23
24	Other (OTHER DIETARY REVENUE)	96,710	24
24.01	Other (SALE: MINOR EQUIPMENT/SUPPLIES)		24.01
24.02	Other (FITNESS CENTER)	8,130	24.02
24.03	Other (PHARM 340B RETAIL/CONTRACT REV)	174,538	24.03
24.04	Other (MISC OTHER)	8,460	24.04
24.05	Other (CRNA PASS THROUGH AND OTHER)		24.05
24.06	Other (MEDICAID EHR)	17,295	24.06
24.07	Other (MEDICARE EHR)	368,898	24.07
25	Total other income (sum of lines 6-24)	3,273,615	25
26	Total (line 5 plus line 25)	3,722,110	26
27	Other expenses (INTEREST EXPENSE)	54,268	27
27.01	Other expenses (LOSS ON DISPOSAL OF ASSET)	1,973	27.01
28	Total other expenses (sum of line 27 and subscripts)	56,241	28
29	Net income (or loss) for the period (line 26 minus line 28)	3,665,869	29

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

COMPONENT CCN: 14-3404

WORKSHEET M-1

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

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	321,869		321,869	-99,221	222,648	-15,254	207,394	1
2	Physician Assistant								2
3	Nurse Practitioner	243,295		243,295		243,295		243,295	3
4	Visiting Nurse								4
5	Other Nurse	129,428		129,428		129,428		129,428	5
6	Clinical Psychologist								6
7	Clinical Social Worker		37,770	37,770		37,770		37,770	7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	212,196		212,196		212,196		212,196	9
10	Subtotal (sum of lines 1 through 9)	906,788	37,770	944,558	-99,221	845,337	-15,254	830,083	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement	96,300	8,820	105,120		105,120		105,120	11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement		10,000	10,000		10,000		10,000	13
14	Subtotal (sum of lines 11 through 13)	96,300	18,820	115,120		115,120		115,120	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		36,398	36,398		36,398		36,398	15
16	Transportation (Health Care Staff)		5,841	5,841		5,841		5,841	16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		48,524	48,524	-48,524				18
19	Other Health Care Costs		39,646	39,646	-2,446	37,200		37,200	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		130,409	130,409	-50,970	79,439		79,439	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,003,088	186,999	1,190,087	-150,191	1,039,896	-15,254	1,024,642	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs				-4,006	-4,006		-4,006	26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)				-4,006	-4,006		-4,006	28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs		39,142	39,142	12,500	51,642	-3,159	48,483	30
31	Total Facility Overhead (sum of lines 29 and 30)		39,142	39,142	12,500	51,642	-3,159	48,483	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,003,088	226,141	1,229,229	-141,697	1,087,532	-18,413	1,069,119	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.

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.80	2,879	4,200	3,360		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.34	4,384	2,100	2,814		3
4	Subtotal (sum of lines 1 through 3)	2.14	7,263		6,174	7,263	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker		622			622	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)	2.14	7,885			7,885	8
9	Physician Services Under Agreements		1,013			1,013	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,024,642	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	-4,006	11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,020,636	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.003925	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	48,483	14
15	Parent provider overhead allocated to facility (see instructions)	1,118,420	15
16	Total overhead (sum of lines 14 and 15)	1,166,903	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,166,903	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,171,483	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	2,196,125	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.

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	2,196,125	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	20,730	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,175,395	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	7,885	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	1,013	5
6	Total adjusted visits (line 4 plus line 5)	8,898	6
7	Adjusted cost per visit (line 3 divided by line 6)	244.48	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		78.54		8
9	Rate for program covered visits (see instructions)	244.48	244.48	244.48	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		2,192		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		535,900		11
12	Program covered visits for mental health services (from contractor records)		140		12
13	Program covered cost from mental health services (line 9 x line 12)		34,227		13
14	Limit adjustment for mental health services (see instructions)		34,227		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		570,127		16
16.01	Total program charges (see instructions)(from contractor's records)		436,640		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)		425,233		16.04
16.05	Total program cost (see instructions)		425,233		16.05
17	Primary payer payments		162		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		38,586		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		82,880		19
20	Net Medicare cost excluding vaccines (see instructions)		425,071		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		4,358		21
22	Total reimbursable Program cost (line 20 plus line 21)		429,429		22
23	Allowable bad debts (see instructions)		20,513		23
23.01	Adjusted reimbursable bad debts (see instructions)		13,333		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		20,513		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		442,762		26
26.01	Sequestration adjustment (see instructions)		8,855		26.01
27	Interim payments		388,331		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		45,576		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	830,083	830,083	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000320	0.001130	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	266	938	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,266	3,222	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,532	4,160	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,024,642	1,024,642	6
7	Total overhead (from Wkst. M-2, line 16)	1,166,903	1,166,903	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005399	0.004060	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,300	4,738	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	11,832	8,898	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	40	141	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	295.80	63.11	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	3	55	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	887	3,471	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)		20,730	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		4,358	16

WARNER HOSPITAL AND HEALTH SERVICES Provider CCN: 14-1303	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/12/2016 Run Time: 09:05 Version: 2016.05 (08/16/2016)

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

COMPONENT CCN: 14-3404

WORKSHEET M-5

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

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				383,650	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	05/04/2016	4,681	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		4,681	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				388,331	
	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		45,576	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				433,907	

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.