

CRAWFORD MEMORIAL HOSPITAL

ROBINSON, ILLINOIS

MEDICARE COST ANALYSIS

YEAR ENDED APRIL 30, 2011

National Government Services, Inc.
Medicare Audit and Reimbursement
P.O. Box 2952
Milwaukee, WI 53201-2952

Dear Sir or Madam:

This cost report of Crawford Memorial Hospital for the fiscal year ended April 30, 2011, includes one Level 20000 Error.

The 20300 error, which reads the cost to charge ratio on Wkst C, Part I, Col. II should not be more than 100% or less than .1%, Line 90 is a result of a majority of revenue generated in this cost center resulting from surgeries being performed by Clinic physicians at the Hospital for Short Stay Surgery. Since the surgery is performed at the hospital, technical component charges are properly billed and posted to the operating room cost center where the cost is incurred. The physician charges and other clinic charges are posted to the Clinic cost center. Therefore, the Clinic cost center does not generate enough charges to cover the expense of running the clinic which includes the cost report allocated overhead expenses.

Board of Directors
Crawford Memorial Hospital

We have compiled the Hospital Health Care Complex Cost Report Form HCFA 2552-10 of Crawford Memorial Hospital for the year ended April 30, 2011, included in the accompanying prescribed form in accordance with Statements on Standard for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

A compilation is limited to presenting in the form prescribed by the Centers for Medicare and Medicaid Services information that is the representation of management. We have not audited or reviewed the cost report referred to above and, accordingly; do not express an opinion or any other form of assurance on it.

The Hospital Health Care Complex Cost Report Form HCFA 2552-10 is presented in accordance with the requirements of the Centers for Medicare and Medicaid Services, which differ from generally accepted accounting principles. Accordingly, the cost report is not designed for those who are not informed about such differences.

Kerby, Ed & Braechel LLP

Carbondale, Illinois
November 15, 2011

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. ELECTRONICALLY FILED COST REPORT DATE: 11/23/2011 TIME: 13:17
 2. MANUALLY SUBMITTED COST REPORT
 3. IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT
 4. MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: 11/23/2011
 1 - AS SUBMITTED 7. CONTRACTOR NO: _____ 11. CONTRACTOR'S VENDOR CODE: _____
 2 - SETTLED WITHOUT AUDIT 8. INITIAL REPORT FOR THIS PROVIDER CCN 12. IF LINE 5, COLUMN 1 IS 4: ENTER
 3 - SETTLED WITH AUDIT 9. FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.
 4 - REOPENED
 5 - AMENDED

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY CRAWFORD MEMORIAL HOSPITAL (14-1343) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 05/01/2010 AND ENDING 04/30/2011, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 11/23/2011 13:17
 QOON.BOC4129sQf1REtPjZdgsxSEK90
 huTDW0WPEeASLfkOS8.gSws4OLYf9
 ABpy1PVs.v0mCKQD

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

 TITLE

PI Encryption: 11/23/2011 13:17
 Ofg0fOB9mg9zWTDQrCsF4FEjDM.P0
 Kp9PB0I6mbtPELHZcPQrVQXyVcUTKp
 yLfNaQeJE10pq6Do

 DATE

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		-348,371	372,298		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF		24,165			5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			103,662		10
10.01 HEALTH CLINIC - RHC II			8,302		10.01
10.02 HEALTH CLINIC - RHC III			-1,684		10.02
11 HEALTH CLINIC - PQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		-324,206	482,578		200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. 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.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1000 NORTH ALLEN STREET P.O.BOX: 1
 2 CITY: ROBINSON STATE: IL ZIP CODE: 62454 COUNTY: CRAWFORD 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N) V XVIII XIX			8	
						6	7	8		
3	HOSPITAL	CRAWFORD MEMORIAL HOSPITAL	14-1343	00014	1	05/01/2005	N	O	P	3
4	SUBPROVIDER - IPF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	CRAWFORD MEMORIAL HOSPITAL	14-Z343	00014		05/01/2005	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	CRAWFORD MEMORIAL HHA	14-7175	00014		08/01/1979	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE									14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	CMH RURAL HEALTH CLINIC	14-3429	00014		11/11/1996	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	PALESTINE RURAL HEALTH CLINIC	14-3486	00014		11/21/2006	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	OBLONG RURAL HEALTH CLINIC	14-3488	00014		05/01/2007	N	O	N	15.02
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: 05/01/2010				TO: 04/30/2011				20
21	TYPE OF CONTROL					11				21

INPATIENT PPS INFORMATION

22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND '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.									1	2
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.									3	N 23

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V 1	XVIII 2	XIX 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 THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

TEACHING HOSPITALS		1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N		57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 21248? IF YES, COMPLETE WORKSHEET D-5.				58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N			60
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	61
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N			63
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
			3	4	5
ENTER IN LINES 65-65.49, 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			
	1	2			
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS					
EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))
			3	4	5

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

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.1/(COL.3+COL.4))
1	2	3	4	5
INPATIENT PSYCHIATRIC FACILITY PPS				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
INPATIENT REHABILITATION FACILITY PPS				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
LONG TERM CARE HOSPITAL PPS				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
TEFRA PROVIDERS				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA?. ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
TITLE V AND XIX INPATIENT SERVICES				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
RURAL PROVIDERS				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			Y 105
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES, COMPLETE WORKSHEET D-2, PART II, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N 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.			N 108
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.	PHY- SICAL	OCCUP- ATIONAL	RESPI- RATORY
		N	N	N N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N	2	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.	1		118
119	WHAT IS THE LIABILITY LIMIT FOR THE MALPRACTICE INSURANCE POLICY? ENTER IN COLUMN 1 THE MONETARY LIMIT PER LAWSUIT. ENTER IN COLUMN 2 THE MONETARY LIMIT PER POLICY YEAR.	6,000,000	6,000,000	119
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N	2	140
-----	--	---	---	-----

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y		144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	N		145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.	N		146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

155	HOSPITAL	Y	2	155
156	SUBPROVIDER - IPF		Y	156
157	SUBPROVIDER - IRF			157
158	SUBPROVIDER - (OTHER)			158
159	SNF			159
160	HHA	N	N	160
161	CMHC			161

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.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.			168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

HOSPITAL AND 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

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE	
1		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
2		Y/N	DATE	V/I
1		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

FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE
1		1	2	3
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	Y	A	4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N		5

APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N
1		1	2
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N	6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N	7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N	8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N	9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N	11
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		Y/N
1		1
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N 15

	PART A		PART B	
	Y/N	DATE	Y/N	DATE
1	2	3	4	
16	Y	07/26/2011	Y	07/26/2011
17	N		N	
18	N		N	
19	N		N	
20	N		N	
21	N		N	

PS&R REPORT DATA		Y/N	DATE	Y/N	DATE
1		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	07/26/2011	Y	07/26/2011
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

HOSPITAL AND 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 RELIEFED 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 DEBRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27

INTEREST EXPENSE

28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31

PURCHASED SERVICES

32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33

PROVIDER-BASED PHYSICIANS

34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	35

HOME OFFICE COSTS

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

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	16,375,753			663,386.00		1
2							2
3							3
4							4
5		1,753,700			16,397.00		5
6		754,543			58,326.00		6
7	21						7
8							8
9	44						9
10		1,204,444	-4,839				10
OTHER WAGES & RELATED COSTS							
11		482,868			6,322.00		11
12							12
13							13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		2,200,307					17
18							18
19		302,163					19
20							20
21							21
22							22
23		377,398					23
24		162,379					24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		162,971	4,925				26
27		1,195,601	-86				27
28							28
29							29
30		360,477					30
31		82,529					31
32		285,564					32
33							33
34		393,720	-205,754				34
35							35
36			205,754				36
37							37
38		571,812					38
39							39
40		490,303					40
41		437,484					41
42		36,296					42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	13,867,510		13,867,510	588,663.00	23.56	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	1,204,444	-4,839	1,199,605			2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	12,663,066	4,839	12,667,905	588,663.00	21.52	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)	482,868		482,868	6,322.00	76.38	4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)	2,200,307		2,200,307		17.37%	5
6	TOTAL (SUM OF LINES 3 THRU 5)	15,346,241	4,839	15,351,080	594,985.00	25.80	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	4,016,757	4,839	4,021,596			7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	3
4 PRIOR YEAR PENSION SERVICE COST	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
 PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT	
0		LABOR	COST	
		1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST			1
2	HOSPITAL			2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA			11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE			13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
14.01	HOSPITAL-BASED HEALTH CLINIC - RHC II			14.01
14.02	HOSPITAL-BASED HEALTH CLINIC - RHC III			14.02
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7175

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		3,116			3,116	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		180.00		117.00	297.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK: 40.00	----- NUMBER OF EMPLOYEES ----- (FULL TIME EQUIVALENT)			TOTAL 3	
	STAFF 1	CONTRACT 2			
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)					3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			1.37	1.37	4
5 OTHER ADMINISTRATIVE PERSONNEL			1.00	1.00	5
6 DIRECT NURSING SERVICE			6.84	6.84	6
7 NURSING SUPERVISOR					7
8 PHYSICAL THERAPY SERVICE			0.60	0.60	8
9 PHYSICAL THERAPY SUPERVISOR					9
10 OCCUPATIONAL THERAPY SERVICE			0.07	0.07	10
11 OCCUPATIONAL THERAPY SUPERVISOR					11
12 SPEECH PATHOLOGY SERVICE					12
13 SPEECH PATHOLOGY SUPERVISOR					13
14 MEDICAL SOCIAL SERVICE					14
15 MEDICAL SOCIAL SERVICE SUPERVISOR					15
16 HOME HEALTH AIDE			1.50	1.50	16
17 HOME HEALTH AIDE SUPERVISOR					17
18 OTHER (SPECIFY)					18

HOME HEALTH AGENCY CBSA CODES

19 ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.		1	19
20 LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE).		99914	20

PPS ACTIVITY

	FULL EPISODES				TOTAL (COLS. 1-4)	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	1,998	281	61	5	2,345	21
22 SKILLED NURSING VISIT CHARGES	300,697	42,151	9,211	755	352,814	22
23 PHYSICAL THERAPY VISITS	690		5	1	696	23
24 PHYSICAL THERAPY VISIT CHARGES	106,621		775	155	107,551	24
25 OCCUPATIONAL THERAPY VISITS	162		2		164	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	25,026		310		25,336	26
27 SPEECH PATHOLOGY VISITS	25				25	27
28 SPEECH PATHOLOGY VISIT CHARGES	3,875				3,875	28
29 MEDICAL SOCIAL SERVICE VISITS	2				2	29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES	426				426	30
31 HOME HEALTH AIDE VISITS	610		3		613	31
32 HOME HEALTH AIDE VISIT CHARGES	43,136		213		43,349	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	3,487	281	71	6	3,845	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	479,781	42,151	10,509	910	533,351	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	186		25	1	212	36
37 TOTAL NUMBER OF OUTLIER EPISODES		5			5	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	5,879	1,182	120		7,181	38

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		Y/N 1	DATE 2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	09/19/1994	2

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 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

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (COLS. 2 + 3) 4
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

	CBSA AT BEGINNING OF COST REPORTING PERIOD 1	CBSA ON/AFTER OF THE COST REPORTING PERIOD (IF APPLICABLE) 2
--	---	--

SNF SERVICES

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

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

	EXPENSES 1	PERCENTAGE 2	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES? 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

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/23/2011 13:04

HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

RHC I
COMPONENT NO: 14-3429

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1000 N ALLEN 1
2 CITY: ROBINSON STATE: IL ZIP CODE: 62454 COUNTY: CRAWFORD 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

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

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 1 2
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

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

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 12
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW. N 13

14 PROVIDER NAME: CCN NUMBER: 14

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

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/23/2011 13:04

HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

RHC II
COMPONENT NO: 14-3486

WORKSHEET S-8

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 209 EAST GRAND PRAIRIE 1
2 CITY: PALESTINE STATE: IL ZIP CODE: 62451 COUNTY: CRAWFORD 2
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS:

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

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 1 2
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

FACILITY HOURS OF OPERATIONS(1)

TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC			0800	1630	0800	1630	0800	1630	0800	1630	0800	1630			11

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

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 12
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW. N 13

14 PROVIDER NAME: CCN NUMBER: 14

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 INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)
Y/N V XVIII XIX 15
N

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.493494	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,441,085	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?				N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				3,527,395	5
6	MEDICAID CHARGES				10,438,387	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				5,151,281	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 2 PLUS LINE 5 MINUS LINE 7)				-182,801	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 9 MINUS LINE 11)					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 13 MINUS LINE 15)					16
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)						
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				-182,801	19

		UNINSURED	INSURED	TOTAL	
		PATIENTS	PATIENTS		
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FAMILY	1,500,518	187,795	1,688,313	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	740,497	92,676	833,172	21
22		92,114	12,561	104,675	22
23	COST OF CHARITY CARE	648,383	80,115	728,497	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)			3,607,042	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			553,324	27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			3,053,718	28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			1,506,992	29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			2,235,489	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,052,688	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSIFI-	
		1	2	(COL. 1 + COL. 2)	CATIONS	
				3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,400,004	1,400,004	-67,504	1
2	00200		885,962	885,962	4,390	2
3	00300		19,820	19,820	-19,820	3
4	00400	162,971	2,880,210	3,043,181	5,777	4
5.01	00540		115	115	25,736	5.01
5.02	00550	162,300	777,554	939,854		5.02
5.03	00560	92,148	79,657	171,805	-50,671	5.03
5.04	00570	255,430	32,657	288,087	-97	5.04
5.05	00580	233,836	241,477	475,313	-25,736	5.05
5.06	00590	451,887	4,315,064	4,766,951	50,671	5.06
6	00600					6
7	00700	360,477	1,031,229	1,391,706	34,080	7
8	00800	82,529	51,938	134,467		8
9	00900	285,564	139,688	425,252		9
10	01000	393,720	376,995	770,715	-402,767	10
11	01100				402,767	11
12	01200					12
13	01300	571,812	79,453	651,265		13
14	01400		172,223	172,223	-172,223	14
15	01500	490,303	1,194,669	1,684,972	-1,079,231	15
16	01600	437,484	109,247	546,731	9,308	16
17	01700	36,296	3,201	39,497		17
19	01900					19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,526,874	266,960	1,793,834	-171,281	30
31	03100	176,868	26,885	203,753	-1,241	31
43	04300		3	3	54,354	43
46	04600	612,435	105,106	717,541	26,639	46
ANCILLARY SERVICE COST CENTERS						
50	05000	708,242	1,078,895	1,787,137	-639,768	50
52	05200				101,611	52
53	05300		121,926	121,926	-121,926	53
54	05400	623,630	791,473	1,415,103	-14,323	54
54.01	05401		190,900	190,900		54.01
60	06000	483,892	915,036	1,398,928	-85,868	60
62	06200				85,868	62
62.30	06250					62.30
65	06500	304,970	143,345	448,315	-1,023	65
66	06600	561,659	152,893	714,552	-39,856	66
69	06900	14,328	38,521	52,849		69
71	07100				820,235	71
72	07200				172,347	72
73	07300				1,093,554	73
76	03950	33,543	26,545	60,088		76
76.01	03951					76.01
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	3,291,040	733,924	4,024,964	125,617	88
88.01	08801	275,857	146,032	421,889	13,457	88.01
88.02	08802	216,789	97,021	313,810	18,278	88.02
90	09000	2,280,961	1,286,117	3,567,078	4,288	90
91	09100	655,899	1,371,066	2,026,965	-11,533	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
101	10100	416,931	131,337	548,268	-8,162	101
SPECIAL PURPOSE COST CENTERS						
113	11300		161,994	161,994	-161,994	113
118		16,200,675	21,577,142	37,777,817	-26,047	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	56,834	114,077	170,911	16,768	192
194	07950					194
194.01	07951		119,445	119,445	10,945	194.01
194.02	07952	23,296	8,204	31,500		194.02
194.03	07953	94,948	21,946	116,894	-1,666	194.03
194.04	07954					194.04
200		16,375,753	21,840,814	38,216,567		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	1,332,500	-56,490	1,276,010	1
2	00200	CAP REL COSTS-MVBLE EQUIP	890,352		890,352	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	3,048,958	-191,530	2,857,428	4
5.01	00540	NONPATIENT TELEPHONES	25,851		25,851	5.01
5.02	00550	DATA PROCESSING	939,854		939,854	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	121,134		121,134	5.03
5.04	00570	ADMITTING	287,990		287,990	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	449,577		449,577	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	4,817,622	-2,591,171	2,226,451	5.06
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	1,425,786	-2,811	1,422,975	7
8	00800	LAUNDRY & LINEN SERVICE	134,467		134,467	8
9	00900	HOUSEKEEPING	425,252		425,252	9
10	01000	DIETARY	367,948		367,948	10
11	01100	CAFETERIA	402,767	-154,247	248,520	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	651,265		651,265	13
14	01400	CENTRAL SERVICES & SUPPLY				14
15	01500	PHARMACY	605,741	-38,615	567,126	15
16	01600	MEDICAL RECORDS & LIBRARY	556,039	-8,301	547,738	16
17	01700	SOCIAL SERVICE	39,497		39,497	17
19	01900	NONPHYSICIAN ANESTHETISTS				19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,622,553	-11,500	1,611,053	30
31	03100	INTENSIVE CARE UNIT	202,512		202,512	31
43	04300	NURSERY	54,357		54,357	43
46	04600	OTHER LONG TERM CARE	744,180		744,180	46
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	1,147,369	-106,950	1,040,419	50
52	05200	DELIVERY ROOM & LABOR ROOM	101,611		101,611	52
53	05300	ANESTHESIOLOGY				53
54	05400	RADIOLOGY-DIAGNOSTIC	1,400,780	-17,959	1,382,821	54
54.01	05401	RADIOLOGY-ULTRASOUND	190,900		190,900	54.01
60	06000	LABORATORY	1,313,060		1,313,060	60
62	06200	WHOLE BLOOD & PKD RED BLOOD CELLS	85,868		85,868	62
62.30	06250	BLOOD CLOTTING FACTORS ADMIN COSTS				62.30
65	06500	RESPIRATORY THERAPY	447,292	-38,253	409,039	65
66	06600	PHYSICAL THERAPY	674,696		674,696	66
69	06900	ELECTROCARDIOLOGY	52,849	-37,038	15,811	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	820,235		820,235	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	172,347		172,347	72
73	07300	DRUGS CHARGED TO PATIENTS	1,093,554		1,093,554	73
76	03950	CARDIAC REHAB	60,088	-12,518	47,570	76
76.01	03951	OCCUPATIONAL MEDICINE & WELLNESS				76.01
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	4,150,581	-247,860	3,902,721	88
88.01	08801	RHC II	435,346	-15,578	419,768	88.01
88.02	08802	RHC III	332,088	-22,541	309,547	88.02
90	09000	CLINIC	3,571,366	-2,438,792	1,132,574	90
91	09100	EMERGENCY	2,015,432	-930,097	1,085,335	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORP				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
101	10100	HOME HEALTH AGENCY	540,106	-32,123	507,983	101
SPECIAL PURPOSE COST CENTERS						
113	11300	INTEREST EXPENSE				113
118		SUBTOTALS (SUM OF LINES 1-117)	37,751,770	-6,954,374	30,797,396	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192	19200	PHYSICIANS' PRIVATE OFFICES	187,679		187,679	192
194	07950	NONREIMBURSEABLE				194
194.01	07951	PROFESSIONAL BUILDINGS	130,390		130,390	194.01
194.02	07952	FOUNDATION SERVICES	31,500		31,500	194.02
194.03	07953	WELLNESS	115,228		115,228	194.03
194.04	07954	RENTED SPACE				194.04
200		TOTAL (SUM OF LINES 118-199)	38,216,567	-6,954,374	31,262,193	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		OTHER	
			LINE #	SALARY		
1	2	3	4	5		
1 R/C HHA MED SUPPLIES	A	MEDICAL SUPPLIES CHRGD TO PA	71		12,186	1
2 R/C COST OF DRUGS	B	DRUGS CHARGED TO PATIENTS	73		1,079,231	2
3 R/C OF EMPLOYEE BENEFITS	C					3
4	C					4
5 R/C OF LTC ADMITTING COSTS	D	OTHER LONG TERM CARE	46	86	11	5
6 R/C POSTAGE	E	OTHER ADMINISTRATIVE AND GENE	5.06		50,671	6
7 R/C CAFETERIA COSTS	F	CAFETERIA	11	205,754	197,013	7
8 R/C COST OF BLOOD	G	WHOLE BLOOD & PCKD RED BLOOD	62		85,868	8
9	H					9
10 R/C DEPR OBLONG CLINIC	I					10
11	I					11
12 R/C DEPR PROF BLDGS	J	PROFESSIONAL BUILDINGS	194.01		10,945	12
13	J	RURAL HEALTH CLINIC (RHC)	88		166,943	13
14	J	RHC II	88.01		9,582	14
15	J	CLINIC	90		22,781	15
16	J	WELLNESS	194.03		4,111	16
17	J	HOME HEALTH AGENCY	101		4,024	17
18 R/C SNF DEPR	K	OTHER LONG TERM CARE	46		26,542	18
19	K					19
20 R/C LABOR/DEL & NB COSTS	L	NURSERY	43	43,443	10,911	20
21	L	DELIVERY ROOM & LABOR ROOM	52	81,214	20,397	21
22 R/C SUPPLIES CHGD TO PTS	M	MEDICAL SUPPLIES CHRGD TO PA	71		980,396	22
23	M					23
24	M					24
25	M					25
26	M					26
27	M					27
28	M					28
29 R/C TRANSCRIPTION TXFR	N	MEDICAL RECORDS & LIBRARY	16		9,308	29
30	N					30
31	N					31
32	O					32
33	O	DRUGS CHARGED TO PATIENTS	73		14,323	33
34	O	IMPL. DEV. CHARGED TO PATIENT	72		172,347	34
35 R/C INTEREST EXPENSE	P	CAP REL COSTS-BLDG & FIXT	1		161,994	35
36	P					36
37 R/C OR COST	Q	OPERATING ROOM	50		116,744	37
38 R/C PALESTINE/OBLONG DRS	R	RHC II	88.01		3,875	38
39	R	RHC III	88.02		18,278	39
40	R	PHYSICIANS' PRIVATE OFFICES	192		16,768	40
41	S					41
42	T					42
43 HEALTHWORKS COST	U	EMPLOYEE BENEFITS	4	4,925	852	43
44 UTILITIES	V	OPERATION OF PLANT	7		34,080	44
45	V					45
46	V					46
47 RECLASS NON PT PHONE COST	W	NONPATIENT TELEPHONES	5.01	22,819	2,917	47
500 TOTAL RECLASSIFICATIONS (SUM OF COLS. 4 & 5 MUST EQUAL SUM OF COLS. 8 & 9)				358,241	3,233,098	500

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
1		6	7	8	9	10
1 R/C HHA MED SUPPLIES	A	HOME HEALTH AGENCY	101		12,186	1
2 R/C COST OF DRUGS	B	PHARMACY	15		1,079,231	2
3 R/C OF EMPLOYEE BENEFITS	C					3
4	C					4
5 R/C OF LTC ADMITTING COSTS	D	ADMITTING	5.04	86	11	5
6 R/C POSTAGE	E	PURCHASING RECEIVING AND STOR	5.03		50,671	6
7 R/C CAFETERIA COSTS	F	DIETARY	10	205,754	197,013	7
8 R/C COST OF BLOOD	G	LABORATORY	60		85,868	8
9	H					9
10 R/C DEPR OBLONG CLINIC	I					9 10
11	I					9 11
12 R/C DEPR PROF BLDGS	J	CAP REL COSTS-BLDG & FIXT	1		218,386	9 12
13	J					9 13
14	J					9 14
15	J					9 15
16	J					9 16
17	J					17
18 R/C SNF DEPR	K	CAP REL COSTS-BLDG & FIXT	1		26,542	9 18
19	K					9 19
20 R/C LABOR/DEL & NB COSTS	L	ADULTS & PEDIATRICS	30	124,657	31,308	20
21	L					21
22 R/C SUPPLIES CHGD TO PTS	M	OPERATING ROOM	50		756,059	22
23	M	CENTRAL SERVICES & SUPPLY	14		172,223	23
24	M	EMERGENCY	91		11,533	24
25	M	ANESTHESIOLOGY	53		5,182	25
26	M	PHYSICAL THERAPY	66		17,366	26
27	M	RESPIRATORY THERAPY	65		1,023	27
28	M	ADULTS & PEDIATRICS	30		15,316	28
29 R/C TRANSCRIPTION TXFR	N	RURAL HEALTH CLINIC (RHC)	88		2,405	29
30	N	CLINIC	90		6,903	30
31	N	INTENSIVE CARE UNIT	31		1,241	31
32	O	OPERATING ROOM	50		453	32
33	O	RADIOLOGY-DIAGNOSTIC	54		14,323	33
34	O	MEDICAL SUPPLIES CHRGD TO PA	71		172,347	34
35 R/C INTEREST EXPENSE	P	INTEREST EXPENSE	113		161,994	10 35
36	P					10 36
37 R/C OR COST	Q	ANESTHESIOLOGY	53		116,744	37
38 R/C PALESTINE/OBLONG DRS	R	RURAL HEALTH CLINIC (RHC)	88		38,921	38
39	R					39
40	R					40
41	S					41
42	T					42
43 HEALTHWORKS COST	U	WELLNESS	194.03	4,925	852	43
44 UTILITIES	V					44
45	V	PHYSICAL THERAPY	66		22,490	45
46	V	CLINIC	90		11,590	46
47 RECLASS NON PT PHONE COST	W	CASHIERING/ACCOUNTS RECEIVABL	5.05	22,819	2,917	47
500 TOTAL RECLASSIFICATIONS (SUM OF COLS. 4 & 5 MUST EQUAL SUM OF COLS. 8 & 9)				358,241	3,233,098	500

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	ACQUISITIONS			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND RETIREMENTS	BALANCE	DEPRECIATED ASSETS
	1	2	3	4	5	6	7
1 LAND	48,365					48,365	1
2 LAND IMPROVEMENTS	1,465,155	20,000		20,000		1,485,155	2
3 BUILDINGS AND FIXTURES	29,817,319	8,262,015		8,262,015	3,092,731	34,986,603	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	9,501,739	1,010,759		1,010,759	134,764	10,377,734	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	40,832,578	9,292,774		9,292,774	3,227,495	46,897,857	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	40,832,578	9,292,774		9,292,774	3,227,495	46,897,857	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL (1)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	14	15
1 CAP REL COSTS-BLDG & FIXT	1,400,004						1,400,004 1
2 CAP REL COSTS-MVBLE EQUIP	885,962						885,962 2
3 TOTAL (SUM OF LINES 1-2)	2,285,966						2,285,966 3

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 INSTR.)	INSURANCE	TAXES	OTHER	TOTAL
							CAPITAL-RELATED COSTS	(SUM OF COLS. 5-7)
	1	2	3	4	5	6	7	8
1 CAP REL COSTS-BLDG & FIXT	36,471,758		36,471,758	0.778488			15,430	15,430 1
2 CAP REL COSTS-MVBLE EQUIP	10,377,739		10,377,739	0.221512			4,390	4,390 2
3 TOTAL (SUM OF LINES 1-2)	46,849,497		46,849,497	1.000000			19,820	19,820 3

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER	TOTAL (2)
						CAPITAL-RELATED COSTS (SEE INSTR.)	(SUM OF COLS. 9-14)
	9	10	11	(SEE INSTR.)	(SEE INSTR.)	14	15
1 CAP REL COSTS-BLDG & FIXT	1,155,076	105,504				15,430	1,276,010 1
2 CAP REL COSTS-MVBLE EQUIP	885,962					4,390	890,352 2
3 TOTAL	2,041,038	105,504				19,820	2,166,362 3

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7	
			COST CENTER	LINE NO.	REF	
	1	2	3	4	5	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	A	-56,490	CAP REL COSTS-BLDG & FIXT	1	10	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2		2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)						3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)						4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)						5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)						6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)						7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)						8
9 PARKING LOT (CHAPTER 21)						9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,017,726				10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)						11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1					12
13 LAUNDRY AND LINEN SERVICE						13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-154,247	CAFETERIA	11		14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS						15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS						16
17 SALE OF DRUGS TO OTHER THAN PATIENTS						17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-8,301	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 OVERPAYMENT						22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29 PHYSICIANS' ASSISTANT						29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3					31
32 CAH HIT ADJ FOR DEPRECIATION AND						32
33 PHYS RECRUITING	A	-233,142	OTHER ADMINISTRATIVE AND GENERA	5.06		33
33.11 EMPLOYEE INJURY	A	-5,101	EMPLOYEE BENEFITS	4		33.11
34 ADVERTISING	A	-105,068	OTHER ADMINISTRATIVE AND GENERA	5.06		34
35 TV ADMINISTRATION	A	-5,084	OTHER ADMINISTRATIVE AND GENERA	5.06		35
36 TV UTILITIES & REPAIR	A	-2,811	OPERATION OF PLANT	7		36
37 PROV FOR BAD DEBT	A	-2,270,205	OTHER ADMINISTRATIVE AND GENERA	5.06		37
38 EMPLOYEE DISCOUNTS	A	-37,796	EMPLOYEE BENEFITS	4		38
39 OTHER A & G	A	-49,997	OTHER ADMINISTRATIVE AND GENERA	5.06		39
40 EMPLOYEE SALES - PHARMACY	B	-38,615	PHARMACY	15		40
41 OTHER INCOME PALESTINE	B	-14,247	RHC II	88.01		41
42 CONSULTING CLINIC	B	-62,196	CLINIC	90		42
43 OTHER INCOME OCC MED	B	-14,126	RHC III	88.02		43
44 PHYSICIAN EXPENSES	A	-8,415	RHC III	88.02		44
45 PHYSICIAN EXPENSES	A	-1,739,963	CLINIC	90		45
46 PHYSICIAN EXPENSES	A	-148,633	EMPLOYEE BENEFITS	4		46
47 PHYSICIAN EXPENSES	A	-247,860	RURAL HEALTH CLINIC (RHC)	88		47
48 PHYSICIAN EXPENSES	A	-1,331	RHC II	88.01		48
49 NON ALLOWABLE ADS	A	-1,030	HOME HEALTH AGENCY	101		49
49.01 NONALLOW CARELINK COST	A	-31,093	HOME HEALTH AGENCY	101		49.01
49.02 MISC INCOME	B	-31,119	OTHER ADMINISTRATIVE AND GENERA	5.06		49.02
49.03 AHA & IHA DUES	A	-12,185	OTHER ADMINISTRATIVE AND GENERA	5.06		49.03
49.04 OB LOCUM TENUMS	A	-11,500	ADULTS & PEDIATRICS	30		49.04
49.05 NONPATIENT CPR	B	-265	OTHER ADMINISTRATIVE AND GENERA	5.06		49.05
49.06 NONPATIENT EMS	B	-180	EMERGENCY	91		49.06
49.07 DONATIONS, PROJECTS	B	-52,735	OTHER ADMINISTRATIVE AND GENERA	5.06		49.07
49.08 DME - A&P	A	-2,822	RADIOLOGY-DIAGNOSTIC	54		49.08
49.09 DME - OR	A	-255	RADIOLOGY-DIAGNOSTIC	54		49.09
49.10 DME -ER	A	-230	RADIOLOGY-DIAGNOSTIC	54		49.10
49.11 DME - PT	A	-193	RADIOLOGY-DIAGNOSTIC	54		49.11

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/23/2011 13:04

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7
			COST CENTER	LINE NO.	
	1	2	3	4	5
49.12 CRNA FEES	A	-106,950	OPERATING ROOM	50	49.12
49.13 ADMIN CLAIMS FEES	A	168,629	OTHER ADMINISTRATIVE AND GENERA	5.06	49.13
49.14 PHYSICIAN FEES	A	-14,459	RADIOLOGY-DIAGNOSTIC	54	49.14
49.15 PHYSICIAN FEES	A	-636,633	CLINIC	90	49.15
50 TOTAL (SUM OF LINES 1 THRU 49)		-6,954,374			50
TRANSFER TO WKST A, COL. 6, LINE 200)					

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 THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4)					5
	TRANSFER COL. 6, LINE 5 TO WKST A-8, COL. 2, LINE 12.					

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----			
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6					6
7					7
8					8
9					9
10					10

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
 - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
 - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
 - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
 - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
 - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
 - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST	A	COST CENTER/ PHYSICIAN IDENTIFIER	AGGREGATE	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2			3	4	5	6	7	8	9
1	65	RESPIRATORY THERAPY	AGGREGATE	38,253	38,253					
2	69	ELECTROCARDIOLOGY	AGGREGATE	37,038	37,038					
3	76	CARDIAC REHAB	AGGREGATE	12,518	12,518					
4	76.01	OCCUPATIONAL MEDICINE &	AGGREGATE							
5	91	EMERGENCY	AGGREGATE	1,226,480	929,917	296,563				
200		TOTAL		1,314,289	1,017,726	296,563				

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION		ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,276,010	1,276,010				1
2	CAP REL COSTS-MVBLE EQUIP	890,352		890,352			2
4	EMPLOYEE BENEFITS	2,857,428	25,726	6,334	2,889,488		4
5.01	NONPATIENT TELEPHONES	25,851	7,625	274	4,640	38,390	5.01
5.02	DATA PROCESSING	939,854	7,470	124,656	33,002	987	5.02
5.03	PURCHASING RECEIVING AND STORES	121,134	35,799	5,675	18,737	987	5.03
5.04	ADMITTING	287,990	3,409	2,568	51,921	987	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	449,577	16,365	1,060	42,908	1,316	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	2,226,451	105,151	13,715	91,886	1,755	5.06
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	1,422,975	91,219	20,436	73,299	439	7
8	LAUNDRY & LINEN SERVICE	134,467	39,348	3,023	16,781		8
9	HOUSEKEEPING	425,252	3,719	1,617	58,066		9
10	DIETARY	367,948	51,917	29,200	38,221	548	10
11	CAFETERIA	248,520	30,468		41,838		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	651,265	7,082		116,271		13
14	CENTRAL SERVICES & SUPPLY		16,179				14
15	PHARMACY	567,126	19,651	77,160	99,697	768	15
16	MEDICAL RECORDS & LIBRARY	547,738	34,436	8,300	88,957	2,303	16
17	SOCIAL SERVICE	39,497	775	292	7,380		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APPRVD						21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,611,053	177,808	117,108	285,124	4,826	30
31	INTENSIVE CARE UNIT	202,512	34,854	8,401	35,964	987	31
43	NURSERY	54,357	6,462		8,834		43
46	OTHER LONG TERM CARE	744,180		7,423	124,549	3,400	46
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,040,419	128,134	177,935	144,013	1,645	50
52	DELIVERY ROOM & LABOR ROOM	101,611	19,387		16,514		52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	1,382,821	52,645	58,530	126,808	1,426	54
54.01	RADIOLOGY-ULTRASOUND	190,900	3,487	370			54.01
60	LABORATORY	1,313,060	34,715	14,730	98,394	987	60
62	WHOLE BLOOD & PCKD RED BLOOD CELLS	85,868	1,705				62
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65	RESPIRATORY THERAPY	409,039	14,971	18,846	62,012		65
66	PHYSICAL THERAPY	674,696	155,332	14,878	114,207	548	66
69	ELECTROCARDIOLOGY	15,811	4,215		2,913		69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	820,235					71
72	IMPL. DEV. CHARGED TO PATIENT	172,347					72
73	DRUGS CHARGED TO PATIENTS	1,093,554					73
76	CARDIAC REHAB	47,570	17,915	9,191	6,821		76
76.01	OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	3,902,721		35,512	618,788	8,230	88
88.01	RHC II	419,768		304	55,822		88.01
88.02	RHC III	309,547		4,757	42,370		88.02
90	CLINIC	1,132,574		36,779	110,005	3,071	90
91	EMERGENCY	1,085,335	54,784	61,374	133,369	1,316	91
92	OBSERVATION BEDS						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
101	HOME HEALTH AGENCY	507,983		8,335	84,778	1,645	101
SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE						113
118	SUBTOTALS (SUM OF LINES 1-117)	30,797,396	1,202,753	868,783	2,854,889	38,171	118
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		10,848				190
192	PHYSICIANS' PRIVATE OFFICES	187,679		11,341	11,557		192
194	NONREIMBURSEABLE						194
194.01	PROFESSIONAL BUILDINGS	130,390					194.01
194.02	FOUNDATION SERVICES	31,500	775		4,737		194.02
194.03	WELLNESS	115,228		10,228	18,305	219	194.03

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PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONE S 5.01
194.04 RENTED SPACE		61,634			194.04
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	31,262,193	1,276,010	890,352	2,889,488	38,390 202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DATA PROCES- SSING	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (COLS.0-4) 4A	
	5.02	5.03	5.04	5.05		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING	1,105,969					5.02
5.03 PURCHASING RECEIVING AND STORES		182,332				5.03
5.04 ADMITTING		625	347,500			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	697,092	208		1,208,526		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	408,877	2,084			2,849,919	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		4,376			1,612,744	7
8 LAUNDRY & LINEN SERVICE		1,875			195,494	8
9 HOUSEKEEPING		2,917			491,571	9
10 DIETARY		1,250			489,084	10
11 CAFETERIA					320,826	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		625			775,243	13
14 CENTRAL SERVICES & SUPPLY					16,179	14
15 PHARMACY		1,875			766,277	15
16 MEDICAL RECORDS & LIBRARY		1,667			683,401	16
17 SOCIAL SERVICE					47,944	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		6,877	65,332	56,187	2,324,315	30
31 INTENSIVE CARE UNIT		417	20,260	15,454	318,849	31
43 NURSERY			6,971	5,318	81,942	43
46 OTHER LONG TERM CARE		2,084			881,636	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		11,669	46,105	177,616	1,727,536	50
52 DELIVERY ROOM & LABOR ROOM			19,844	15,137	172,493	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		4,584	25,965	277,508	1,930,287	54
54.01 RADIOLOGY-ULTRASOUND		5,001	7,863	47,770	255,391	54.01
60 LABORATORY		29,590	41,761	255,312	1,788,549	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS			3,489	4,326	95,388	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		2,084	11,500	25,817	544,269	65
66 PHYSICAL THERAPY		2,084	8,202	53,437	1,023,384	66
69 ELECTROCARDIOLOGY			2,463	8,366	33,768	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		65,639	31,910	40,289	958,073	71
72 IMPL. DEV. CHARGED TO PATIENT		11,669	5,579	8,826	198,421	72
73 DRUGS CHARGED TO PATIENTS			48,711	106,138	1,248,403	73
76 CARDIAC REHAB		417	9	3,525	85,448	76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		9,794			4,575,045	88
88.01 RHC II		1,250			477,144	88.01
88.02 RHC III		417			357,091	88.02
90 CLINIC		6,877	203	22,602	1,312,111	90
91 EMERGENCY		2,501	1,333	67,949	1,407,961	91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY		1,042		16,949	620,732	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	1,105,969	181,498	347,500	1,208,526	30,666,918	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEN					10,848	190
192 PHYSICIANS' PRIVATE OFFICES					210,577	192
194 NONREIMBURSABLE						194
194.01 PROFESSIONAL BUILDINGS					130,390	194.01
194.02 FOUNDATION SERVICES					37,012	194.02
194.03 WELLNESS		834			144,814	194.03

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	DATA PROCESSING 5.02	PURCHASING RECEIVING AND STORE 5.03	ADMITTING 5.04	CASHIERING /ACCOUNTS RECEIVABLE 5.05	SUBTOTAL (COLS.0-4) 4A	
194.04 RENTED SPACE					61,634	194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,105,969	182,332	347,500	1,208,526	31,262,193	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	OTHER ADMN NISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	2,849,919					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	161,768	1,774,512				7
8 LAUNDRY & LINEN SERVICE	19,609	46,713	261,816			8
9 HOUSEKEEPING	49,308	4,416		545,295		9
10 DIETARY	49,058	61,634	4,604	20,034	624,414	10
11 CAFETERIA	32,181	36,171		11,758		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	77,762	8,408		2,733		13
14 CENTRAL SERVICES & SUPPLY	1,623	19,208		6,244		14
15 PHARMACY	76,862	23,329		7,583		15
16 MEDICAL RECORDS & LIBRARY	68,549	40,881		13,288		16
17 SOCIAL SERVICE	4,809	920		299		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	233,143	211,083	98,274	68,613	245,796	30
31 INTENSIVE CARE UNIT	31,982	41,378	2,193	13,450	12,849	31
43 NURSERY	8,219	7,672		2,494		43
46 OTHER LONG TERM CARE	88,433	162,788	72,276	52,915	303,634	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	173,282	152,117	33,379	49,446	10,181	50
52 DELIVERY ROOM & LABOR ROOM	17,302	23,016		7,482		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	193,619	62,499	16,636	20,315		54
54.01 RADIOLOGY-ULTRASOUND	25,617	4,140		1,346		54.01
60 LABORATORY	179,402	41,212	291	13,396		60
62 WHOLE BLOOD & PKCD RED BLOOD CELLS	9,568	2,024		658		62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						
65 RESPIRATORY THERAPY	54,593	17,773	1,673	5,777		65
66 PHYSICAL THERAPY	102,652	184,406	5,324	59,942		66
69 ELECTROCARDIOLOGY	3,387	5,004		1,627		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	96,100					71
72 IMPL. DEV. CHARGED TO PATIENT	19,903					72
73 DRUGS CHARGED TO PATIENTS	125,222					73
76 CARDIAC REHAB	8,571	21,268		6,913		76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	458,904	249,240	3,482	81,017		88
88.01 RHC II	47,860	45,830	536			88.01
88.02 RHC III	35,818		447			88.02
90 CLINIC	131,613	113,333	3,540	36,839		90
91 EMERGENCY	141,227	65,038	14,221	21,141	51,954	91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY	62,263	8,279		2,691		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,790,209	1,659,780	256,876	508,001	624,414	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,088	12,879		4,186		190
192 PHYSICIANS' PRIVATE OFFICES	21,122					192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	13,079	36,723		11,937		194.01
194.02 FOUNDATION SERVICES	3,713	920		299		194.02
194.03 WELLNESS	14,526	64,210	4,940	20,872		194.03

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	OTHER ADMI NISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10	
194.04 RENTED SPACE	6,182					194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,849,919	1,774,512	261,816	545,295	624,414	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	400,936					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	15,621	879,767				13
14 CENTRAL SERVICES & SUPPLY			43,254			14
15 PHARMACY	12,150	54,970		941,171		15
16 MEDICAL RECORDS & LIBRARY	24,299				830,418	16
17 SOCIAL SERVICE	1,736	7,891				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	59,012	273,271			39,913	30
31 INTENSIVE CARE UNIT	5,207	26,003			10,978	31
43 NURSERY	1,736	6,744			3,777	43
46 OTHER LONG TERM CARE	34,713	157,176				46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	22,563	101,961			126,171	50
52 DELIVERY ROOM & LABOR ROOM	3,471	12,610			10,752	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	20,828				197,154	54
54.01 RADIOLOGY-ULTRASOUND					33,934	54.01
60 LABORATORY	19,092				181,364	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS					3,073	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	12,150	58,424			18,340	65
66 PHYSICAL THERAPY	19,092				37,960	66
69 ELECTROCARDIOLOGY					5,943	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			36,766		28,620	71
72 IMPL. DEV. CHARGED TO PATIENT			6,488		6,270	72
73 DRUGS CHARGED TO PATIENTS				941,171	75,397	73
76 CARDIAC REHAB	1,736				2,504	76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	74,632					88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC	26,035					90
91 EMERGENCY	24,299	108,448			48,268	91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY	15,621	72,269				101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	393,993	879,767	43,254	941,171	830,418	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES	1,736					194.02
194.03 WELLNESS	5,207					194.03

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	400,936	879,767	43,254	941,171	830,418	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL					5.06
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	63,599				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	31,799	3,585,219		3,585,219	30
31 INTENSIVE CARE UNIT		462,889		462,889	31
43 NURSERY		112,584		112,584	43
46 OTHER LONG TERM CARE	31,800	1,785,371		1,785,371	46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		2,396,636		2,396,636	50
52 DELIVERY ROOM & LABOR ROOM		247,126		247,126	52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC		2,441,338		2,441,338	54
54.01 RADIOLOGY-ULTRASOUND		320,428		320,428	54.01
60 LABORATORY		2,223,306		2,223,306	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS		110,711		110,711	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY		712,999		712,999	65
66 PHYSICAL THERAPY		1,432,760		1,432,760	66
69 ELECTROCARDIOLOGY		49,729		49,729	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		1,119,559		1,119,559	71
72 IMPL. DEV. CHARGED TO PATIENT		231,082		231,082	72
73 DRUGS CHARGED TO PATIENTS		2,390,193		2,390,193	73
76 CARDIAC REHAB		126,440		126,440	76
76.01 OCCUPATIONAL MEDICINE & WELLNESS					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		5,442,320		5,442,320	88
88.01 RHC II		571,370		571,370	88.01
88.02 RHC III		393,356		393,356	88.02
90 CLINIC		1,623,471		1,623,471	90
91 EMERGENCY		1,882,557		1,882,557	91
92 OBSERVATION BRDS					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
101 HOME HEALTH AGENCY		781,855		781,855	101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	63,599	30,443,299		30,443,299	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		29,001		29,001	190
192 PHYSICIANS' PRIVATE OFFICES		231,699		231,699	192
194 NONREIMBURSEABLE					194
194.01 PROFESSIONAL BUILDINGS		192,129		192,129	194.01
194.02 FOUNDATION SERVICES		43,680		43,680	194.02
194.03 WELLNESS		254,569		254,569	194.03

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	17	24	25	26	
194.04 RENTED SPACE		67,816		67,816	194.04
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	63,599	31,262,193		31,262,193	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS		25,726	6,334	32,060	32,060	4
5.01 NONPATIENT TELEPHONES		7,625	274	7,899	51	5.01
5.02 DATA PROCESSING		7,470	124,656	132,126	366	5.02
5.03 PURCHASING RECEIVING AND STORES		35,799	5,675	41,474	208	5.03
5.04 ADMITTING		3,409	2,568	5,977	576	5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE		16,365	1,060	17,425	476	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL		105,151	13,715	118,866	1,019	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT		91,219	20,436	111,655	813	7
8 LAUNDRY & LINEN SERVICE		39,348	3,023	42,371	186	8
9 HOUSEKEEPING		3,719	1,617	5,336	644	9
10 DIETARY		51,917	29,200	81,117	424	10
11 CAFETERIA		30,468		30,468	464	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		7,082		7,082	1,290	13
14 CENTRAL SERVICES & SUPPLY		16,179		16,179		14
15 PHARMACY		19,651	77,160	96,811	1,106	15
16 MEDICAL RECORDS & LIBRARY		34,436	8,300	42,736	987	16
17 SOCIAL SERVICE		775	292	1,067	82	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		177,808	117,108	294,916	3,163	30
31 INTENSIVE CARE UNIT		34,854	8,401	43,255	399	31
43 NURSERY		6,462		6,462	98	43
46 OTHER LONG TERM CARE			7,423	7,423	1,382	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		128,134	177,935	306,069	1,598	50
52 DELIVERY ROOM & LABOR ROOM		19,387		19,387	183	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		52,645	58,530	111,175	1,407	54
54.01 RADIOLOGY-ULTRASOUND		3,487	370	3,857		54.01
60 LABORATORY		34,715	14,730	49,445	1,092	60
62 WHOLE BLOOD & PKCD RED BLOOD CELLS		1,705		1,705		62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY		14,971	18,846	33,817	688	65
66 PHYSICAL THERAPY		155,332	14,878	170,210	1,267	66
69 ELECTROCARDIOLOGY		4,215		4,215	32	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB		17,915	9,191	27,106	76	76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			35,512	35,512	6,869	88
88.01 RHC II			304	304	619	88.01
88.02 RHC III			4,757	4,757	470	88.02
90 CLINIC			36,779	36,779	1,220	90
91 EMERGENCY		54,784	61,374	116,158	1,480	91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY			8,335	8,335	941	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		1,202,753	868,783	2,071,536	31,676	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		10,848		10,848		190
192 PHYSICIANS' PRIVATE OFFICES			11,341	11,341	128	192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES		775		775	53	194.02
194.03 WELLNESS			10,228	10,228	203	194.03

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4
194.04 RENTED SPACE		61,634		61,634	194.04
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)		1,276,010	890,352	2,166,362	32,060 202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NONPATIENT TELEPHONE S	DATA PROCE SSING	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	
	5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES	7,950					5.01
5.02 DATA PROCESSING	204	132,696				5.02
5.03 PURCHASING RECEIVING AND STORES	204		41,886			5.03
5.04 ADMITTING	204		144	6,901		5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	273	83,638	48		101,860	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	363	49,058	479			5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	91		1,005			7
8 LAUNDRY & LINEN SERVICE			431			8
9 HOUSEKEEPING			670			9
10 DIETARY	114		287			10
11 CAFETERIA						11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION			144			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	159		431			15
16 MEDICAL RECORDS & LIBRARY	477		383			16
17 SOCIAL SERVICE						17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	999		1,580	1,301	4,734	30
31 INTENSIVE CARE UNIT	204		96	402	1,302	31
43 NURSERY				138	448	43
46 OTHER LONG TERM CARE	704		479			46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	341		2,681	915	14,966	50
52 DELIVERY ROOM & LABOR ROOM				394	1,275	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	295		1,053	515	23,413	54
54.01 RADIOLOGY-ULTRASOUND			1,149	156	4,025	54.01
60 LABORATORY	204		6,797	829	21,513	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS				69	365	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY			479	228	2,175	65
66 PHYSICAL THERAPY	114		479	163	4,503	66
69 ELECTROCARDIOLOGY				49	705	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			15,077	634	3,395	71
72 IMPL. DEV. CHARGED TO PATIENT			2,681	111	744	72
73 DRUGS CHARGED TO PATIENTS				967	8,943	73
76 CARDIAC REHAB			96		297	76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,705		2,250			88
88.01 RHC II			287			88.01
88.02 RHC III			96			88.02
90 CLINIC	636		1,580	4	1,904	90
91 EMERGENCY	273		574	26	5,725	91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY	341		239		1,428	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	7,905	132,696	41,695	6,901	101,860	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES						194.02
194.03 WELLNESS	45		191			194.03

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PART II

COST CENTER DESCRIPTION	NONPATIENT TELEPHONE S	DATA PROCE SSING	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	
	5.01	5.02	5.03	5.04	5.05	
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	7,950	132,696	41,886	6,901	101,860	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	OTHER ADMNISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	169,785					5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	9,638	123,202				7
8 LAUNDRY & LINEN SERVICE	1,168	3,243	47,399			8
9 HOUSEKEEPING	2,938	307		9,895		9
10 DIETARY	2,923	4,279	834	364	90,342	10
11 CAFETERIA	1,917	2,511		213		11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	4,633	584		50		13
14 CENTRAL SERVICES & SUPPLY	97	1,334		113		14
15 PHARMACY	4,579	1,620		138		15
16 MEDICAL RECORDS & LIBRARY	4,084	2,838		241		16
17 SOCIAL SERVICE	287	64		5		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	13,890	14,655	17,790	1,245	35,562	30
31 INTENSIVE CARE UNIT	1,905	2,873	397	244	1,859	31
43 NURSERY	490	533		45		43
46 OTHER LONG TERM CARE	5,269	11,302	13,085	960	43,931	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	10,324	10,561	6,043	897	1,473	50
52 DELIVERY ROOM & LABOR ROOM	1,031	1,598		136		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	11,535	4,339	3,012	369		54
54.01 RADIOLOGY-ULTRASOUND	1,526	287		24		54.01
60 LABORATORY	10,688	2,861	53	243		60
62 WHOLE BLOOD & PKCD RED BLOOD CELLS	570	141		12		62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	3,253	1,234	303	105		65
66 PHYSICAL THERAPY	6,116	12,803	964	1,088		66
69 ELECTROCARDIOLOGY	202	347		30		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	5,725					71
72 IMPL. DEV. CHARGED TO PATIENT	1,186					72
73 DRUGS CHARGED TO PATIENTS	7,460					73
76 CARDIAC REHAB	511	1,477		125		76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	27,335	17,304	630	1,470		88
88.01 RHC II	2,851	3,182	97			88.01
88.02 RHC III	2,134		81			88.02
90 CLINIC	7,841	7,869	641	668		90
91 EMERGENCY	8,414	4,515	2,575	384	7,517	91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY	3,709	575		49		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	166,229	115,236	46,505	9,218	90,342	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	65	894		76		190
192 PHYSICIANS' PRIVATE OFFICES	1,258					192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	779	2,550		217		194.01
194.02 FOUNDATION SERVICES	221	64		5		194.02
194.03 WELLNESS	865	4,458	894	379		194.03

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PART II

COST CENTER DESCRIPTION	OTHER ADMINISTRATIVE AND GENERAL 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	DIETARY 10	
194.04 RENTED SPACE	368					194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	169,785	123,202	47,399	9,895	90,342	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	35,573					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,386	15,169				13
14 CENTRAL SERVICES & SUPPLY			17,723			14
15 PHARMACY	1,078	948		106,870		15
16 MEDICAL RECORDS & LIBRARY	2,156				53,902	16
17 SOCIAL SERVICE	154	136				17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,236	4,713			2,590	30
31 INTENSIVE CARE UNIT	462	448			712	31
43 NURSERY	154	116			245	43
46 OTHER LONG TERM CARE	3,080	2,710				46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,002	1,758			8,188	50
52 DELIVERY ROOM & LABOR ROOM	308	217			698	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,848				12,807	54
54.01 RADIOLOGY-ULTRASOUND					2,202	54.01
60 LABORATORY	1,694				11,770	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS					199	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	1,078	1,007			1,190	65
66 PHYSICAL THERAPY	1,694				2,463	66
69 ELECTROCARDIOLOGY					386	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			15,065		1,857	71
72 IMPL. DEV. CHARGED TO PATIENT			2,658		407	72
73 DRUGS CHARGED TO PATIENTS				106,870	4,893	73
76 CARDIAC REHAB	154				163	76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	6,621					88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC	2,310					90
91 EMERGENCY	2,156	1,870			3,132	91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY	1,386	1,246				101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	34,957	15,169	17,723	106,870	53,902	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES	154					194.02
194.03 WELLNESS	462					194.03

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PART II

COST CENTER DESCRIPTION	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	35,573	15,169	17,723	106,870	53,902	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	17	24	25	26	
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE	1,795				17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	897	403,271		403,271	30
31 INTENSIVE CARE UNIT		54,558		54,558	31
43 NURSERY		8,729		8,729	43
46 OTHER LONG TERM CARE	898	91,223		91,223	46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		367,816		367,816	50
52 DELIVERY ROOM & LABOR ROOM		25,227		25,227	52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC		171,768		171,768	54
54.01 RADIOLOGY-ULTRASOUND		13,226		13,226	54.01
60 LABORATORY		107,189		107,189	60
62 WHOLE BLOOD & PKCD RED BLOOD CELLS		3,061		3,061	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY		45,557		45,557	65
66 PHYSICAL THERAPY		201,864		201,864	66
69 ELECTROCARDIOLOGY		5,966		5,966	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		41,753		41,753	71
72 IMPL. DEV. CHARGED TO PATIENT		7,787		7,787	72
73 DRUGS CHARGED TO PATIENTS		129,133		129,133	73
76 CARDIAC REHAB		30,005		30,005	76
76.01 OCCUPATIONAL MEDICINE & WELLNESS					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		99,696		99,696	88
88.01 RHC II		7,340		7,340	88.01
88.02 RHC III		7,538		7,538	88.02
90 CLINIC		61,452		61,452	90
91 EMERGENCY		154,799		154,799	91
92 OBSERVATION BEDS					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
101 HOME HEALTH AGENCY		18,249		18,249	101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)	1,795	2,057,207		2,057,207	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		11,883		11,883	190
192 PHYSICIANS' PRIVATE OFFICES		12,727		12,727	192
194 NONREIMBURSEABLE					194
194.01 PROFESSIONAL BUILDINGS		3,546		3,546	194.01
194.02 FOUNDATION SERVICES		1,272		1,272	194.02
194.03 WELLNESS		17,725		17,725	194.03

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	17	24	25	26	
194.04 RENTED SPACE		62,002		62,002	194.04
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,795	2,166,362		2,166,362	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP	CAP	EMPLOYEE	NONPATIENT	DATA PROC
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT DOLLAR VALUE NEW	BENEFITS GROSS SAL	TELEPHONE S #OF PHONES	SSING MACHINE TIME
	1	2	4	5.01	5.02
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT	82,336				1
2 CAP REL COSTS-MVBLE EQUIP		888,126			2
4 EMPLOYEE BENEFITS	1,660	6,318	14,210,286		4
5.01 NONPATIENT TELEPHONES	492	273	22,819	350	5.01
5.02 DATA PROCESSING	482	124,344	162,300	9	5.02
5.03 PURCHASING RECEIVING AND STORES	2,310	5,661	92,148	9	5.03
5.04 ADMITTING	220	2,562	255,344	9	5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	1,056	1,057	211,017	12	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	6,785	13,681	451,887	16	5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	5,886	20,385	360,477	4	7
8 LAUNDRY & LINEN SERVICE	2,539	3,015	82,529		8
9 HOUSEKEEPING	240	1,613	285,564		9
10 DIETARY	3,350	29,127	187,966	5	10
11 CAFETERIA	1,966		205,754		11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	457		571,812		13
14 CENTRAL SERVICES & SUPPLY	1,044				14
15 PHARMACY	1,268	76,967	490,303	7	15
16 MEDICAL RECORDS & LIBRARY	2,222	8,279	437,484	21	16
17 SOCIAL SERVICE	50	291	36,296		17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	11,473	116,815	1,402,217	44	30
31 INTENSIVE CARE UNIT	2,249	8,380	176,866	9	31
43 NURSERY	417		43,443		43
46 OTHER LONG TERM CARE		7,404	612,521	31	46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	8,268	177,492	708,242	15	50
52 DELIVERY ROOM & LABOR ROOM	1,251		81,214		52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	3,397	58,384	623,630	13	54
54.01 RADIOLOGY-ULTRASOUND	225	369			54.01
60 LABORATORY	2,240	14,693	483,892	9	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	110				62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY	966	18,799	304,970		65
66 PHYSICAL THERAPY	10,023	14,841	561,659	5	66
69 ELECTROCARDIOLOGY	272		14,328		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIAC REHAB	1,156	9,168	33,543		76
76.01 OCCUPATIONAL MEDICINE & WELLNESS					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		35,423	3,043,180	75	88
88.01 RHC II		303	274,526		88.01
88.02 RHC III		4,745	208,374		88.02
90 CLINIC		36,687	540,998	28	90
91 EMERGENCY	3,535	61,221	655,899	12	91
92 OBSERVATION BEDS					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
101 HOME HEALTH AGENCY		8,314	416,931	15	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	77,609	866,611	14,040,133	348	10,000 118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	700				190
192 PHYSICIANS' PRIVATE OFFICES		11,313	56,834		192
194 NONREIMBURSABLE					194
194.01 PROFESSIONAL BUILDINGS					194.01
194.02 FOUNDATION SERVICES	50		23,296		194.02
194.03 WELLNESS		10,202	90,023	2	194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW 2	EMPLOYEE BENEFITS GROSS SAL 4	NONPATIENT TELEPHONE S #OF PHONES 5.01	DATA PROCE SSING MACHINE TIME 5.02	
194.04 RENTED SPACE	3,977					194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,276,010	890,352	2,889,488	38,390	1,105,969	202
203 UNIT COST MULT-WS B PT I	15.497595	1.002506	0.203338	109.685714	110.596900	203
204 COST TO BE ALLOC PER B PT II			32,060	7,950	132,696	204
205 UNIT COST MULT-WS B PT II			0.002256	22.714286	13.269600	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING RECEIVING AND STORE COST REQ'S 5.03	ADMITTING INPATIENT REVENUE 5.04	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE 5.05	RECON-CILIATION 5A.06	OTHER ADMINSTRATIVE AND GENERAL ACCUM COST 5.06	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES	875					5.03
5.04 ADMITTING	3	11,956,884				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	1		54,515,060			5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	10			-2,849,919	28,412,274	5.06
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	21				1,612,744	7
8 LAUNDRY & LINEN SERVICE	9				195,494	8
9 HOUSEKEEPING	14				491,571	9
10 DIETARY	6				489,084	10
11 CAFETERIA					320,826	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3				775,243	13
14 CENTRAL SERVICES & SUPPLY					16,179	14
15 PHARMACY	9				766,277	15
16 MEDICAL RECORDS & LIBRARY	8				683,401	16
17 SOCIAL SERVICE					47,944	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	33	2,248,018	2,534,472		2,324,315	30
31 INTENSIVE CARE UNIT	2	697,122	697,122		318,849	31
43 NURSERY		239,862	239,862		81,942	43
46 OTHER LONG TERM CARE	10				881,636	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	56	1,586,395	8,011,903		1,727,536	50
52 DELIVERY ROOM & LABOR ROOM		682,785	682,785		172,493	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	22	893,396	12,518,638		1,930,287	54
54.01 RADIOLOGY-ULTRASOUND	24	270,540	2,154,833		255,391	54.01
60 LABORATORY	142	1,436,919	11,516,611		1,788,549	60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS		120,058	195,136		95,388	62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	10	395,686	1,164,567		544,269	65
66 PHYSICAL THERAPY	10	282,209	2,410,440		1,023,384	66
69 ELECTROCARDIOLOGY		84,754	377,388		33,768	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	315	1,097,974	1,817,376		958,073	71
72 IMPL. DEV. CHARGED TO PATIENT	56	191,947	398,121		198,421	72
73 DRUGS CHARGED TO PATIENTS		1,676,053	4,787,688		1,248,403	73
76 CARDIAC REHAB	2	312	159,014		85,448	76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	47				4,575,045	88
88.01 RHC II	6				477,144	88.01
88.02 RHC III	2				357,091	88.02
90 CLINIC	33	6,981	1,019,537		1,312,111	90
91 EMERGENCY	12	45,873	3,065,042		1,407,961	91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY	5		764,525		620,732	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	871	11,956,884	54,515,060	-2,849,919	27,816,999	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					10,848	190
192 PHYSICIANS' PRIVATE OFFICES					210,577	192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS					130,390	194.01
194.02 FOUNDATION SERVICES					37,012	194.02
194.03 WELLNESS	4				144,814	194.03

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	PURCHASING RECEIVING AND STORE COST REQ'S 5.03	ADMITTING INPATIENT REVENUE 5.04	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE 5.05	RECON- CILIATION 5A.06	OTHER ADMI NISTRATIVE AND GENER ACCUM COST 5.06		
194.04 RENTED SPACE					61,634	194.04	
200 CROSS FOOT ADJUSTMENTS						200	
201 NEGATIVE COST CENTER						201	
202 COST TO BE ALLOC PER B PT I	182,332	347,500	1,208,526		2,849,919	202	
203 UNIT COST MULT-WS B PT I	208.379429	0.029063	0.022169		0.100306	203	
204 COST TO BE ALLOC PER B PT II	41,886	6,901	101,860		169,785	204	
205 UNIT COST MULT-WS B PT II	47.869714	0.000577	0.001868		0.005976	205	

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA
	SQUARE FEET	POUNDS	SQUARE FEET	MEALS	FTE'S
	7	8	9	10	11
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORES					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL					5.06
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT	96,450				7
8 LAUNDRY & LINEN SERVICE	2,539	186,226			8
9 HOUSEKEEPING	240		91,180		9
10 DIETARY	3,350	3,275	3,350	57,100	10
11 CAFETERIA	1,966		1,966		231
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	457		457		9
14 CENTRAL SERVICES & SUPPLY	1,044		1,044		14
15 PHARMACY	1,268		1,268		7
16 MEDICAL RECORDS & LIBRARY	2,222		2,222		14
17 SOCIAL SERVICE	50		50		1
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	11,473	69,900	11,473	22,477	34
31 INTENSIVE CARE UNIT	2,249	1,560	2,249	1,175	3
43 NURSERY	417		417		1
46 OTHER LONG TERM CARE	8,848	51,409	8,848	27,766	20
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	8,268	23,742	8,268	931	13
52 DELIVERY ROOM & LABOR ROOM	1,251		1,251		2
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	3,397	11,833	3,397		12
54.01 RADIOLOGY-ULTRASOUND	225		225		54.01
60 LABORATORY	2,240	207	2,240		11
62 WHOLE BLOOD & PCKD RED BLOOD CELLS	110		110		60
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS					62.30
65 RESPIRATORY THERAPY	966	1,190	966		7
66 PHYSICAL THERAPY	10,023	3,787	10,023		11
69 ELECTROCARDIOLOGY	272		272		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIAC REHAB	1,156		1,156		1
76.01 OCCUPATIONAL MEDICINE & WELLNESS					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	13,547	2,477	13,547		43
88.01 RHC II	2,491	381			88.01
88.02 RHC III		318			88.02
90 CLINIC	6,160	2,518	6,160		15
91 EMERGENCY	3,535	10,115	3,535	4,751	14
92 OBSERVATION BEDS					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
101 HOME HEALTH AGENCY	450		450		9
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	90,214	182,712	84,944	57,100	227
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	700		700		190
192 PHYSICIANS' PRIVATE OFFICES					192
194 NONREIMBURSABLE					194
194.01 PROFESSIONAL BUILDINGS	1,996		1,996		194.01
194.02 FOUNDATION SERVICES	50		50		1
194.03 WELLNESS	3,490	3,514	3,490		3

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
	SQUARE FEET	POUNDS	SQUARE FEET	MEALS	FTE'S	
	7	8	9	10	11	
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,774,512	261,816	545,295	624,414	400,936	202
203 UNIT COST MULT-WS B PT I	18.398258	1.405905	5.980423	10.935447	1,735.653680	203
204 COST TO BE ALLOC PER B PT II	123,202	47,399	9,895	90,342	35,573	204
205 UNIT COST MULT-WS B PT II	1.277367	0.254524	0.108522	1.582172	153.995671	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME	
	13	14	15	16	17	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 NONPATIENT TELEPHONES						5.01
5.02 DATA PROCESSING						5.02
5.03 PURCHASING RECEIVING AND STORES						5.03
5.04 ADMITTING						5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL						5.06
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	229,457					13
14 CENTRAL SERVICES & SUPPLY		100				14
15 PHARMACY	14,337		100			15
16 MEDICAL RECORDS & LIBRARY				52,730,998		16
17 SOCIAL SERVICE	2,058				100	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	71,273			2,534,472	50	30
31 INTENSIVE CARE UNIT	6,782			697,122		31
43 NURSERY	1,759			239,862		43
46 OTHER LONG TERM CARE	40,994				50	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	26,593			8,011,903		50
52 DELIVERY ROOM & LABOR ROOM	3,289			682,785		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC				12,518,638		54
54.01 RADIOLOGY-ULTRASOUND				2,154,833		54.01
60 LABORATORY				11,516,611		60
62 WHOLE BLOOD & PCKD RED BLOOD CELLS				195,136		62
62.30 BLOOD CLOTTING FACTORS ADMIN COSTS						62.30
65 RESPIRATORY THERAPY	15,238			1,164,567		65
66 PHYSICAL THERAPY				2,410,440		66
69 ELECTROCARDIOLOGY				377,388		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		85		1,817,376		71
72 IMPL. DEV. CHARGED TO PATIENT		15		398,121		72
73 DRUGS CHARGED TO PATIENTS			100	4,787,688		73
76 CARDIAC REHAB				159,014		76
76.01 OCCUPATIONAL MEDICINE & WELLNESS						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC						90
91 EMERGENCY	28,285			3,065,042		91
92 OBSERVATION BEDS						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
101 HOME HEALTH AGENCY	18,849					101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	229,457	100	100	52,730,998	100	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES						194.02
194.03 WELLNESS						194.03

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME	
	13	14	15	16	17	
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	879,767	43,254	941,171	830,418	63,599	202
203 UNIT COST MULT-WS B PT I	3.834126	432.540000	9,411.710000	0.015748	635.990000	203
204 COST TO BE ALLOC PER B PT II	15,169	17,723	106,870	53,902	1,795	204
205 UNIT COST MULT-WS B PT II	0.066108	177.230000	1,068.700000	0.001022	17.950000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT	1
2	CAP REL COSTS-MVBLE EQUIP	2
4	EMPLOYEE BENEFITS	4
5.01	NONPATIENT TELEPHONES	5.01
5.02	DATA PROCESSING	5.02
5.03	PURCHASING RECEIVING AND STORES	5.03
5.04	ADMITTING	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	5.06
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 SRVCES-SALARY & FRINGES APPRVD	21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD	22
23	PARAMED ED PRGM- (SPECIFY)	23
INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	30
31	INTENSIVE CARE UNIT	31
43	NURSERY	43
46	OTHER LONG TERM CARE	46
ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	50
52	DELIVERY ROOM & LABOR ROOM	52
53	ANESTHESIOLOGY	53
54	RADIOLOGY-DIAGNOSTIC	54
54.01	RADIOLOGY-ULTRASOUND	54.01
60	LABORATORY	60
62	WHOLE BLOOD & PCKD RED BLOOD CELLS	62
62.30	BLOOD CLOTTING FACTORS ADMIN COSTS	62.30
65	RESPIRATORY THERAPY	65
66	PHYSICAL THERAPY	66
69	ELECTROCARDIOLOGY	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	71
72	IMPL. DEV. CHARGED TO PATIENT	72
73	DRUGS CHARGED TO PATIENTS	73
76	CARDIAC REHAB	76
76.01	OCCUPATIONAL MEDICINE & WELLNESS	76.01
76.97	CARDIAC REHABILITATION	76.97
76.98	HYPERBARIC OXYGEN THERAPY	76.98
76.99	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS		
88	RURAL HEALTH CLINIC (RHC)	88
88.01	RHC II	88.01
88.02	RHC III	88.02
90	CLINIC	90
91	EMERGENCY	91
92	OBSERVATION BEDS	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
101	HOME HEALTH AGENCY	101
SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	118
NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190
192	PHYSICIANS' PRIVATE OFFICES	192
194	NONREIMBURSEABLE	194
194.01	PROFESSIONAL BUILDINGS	194.01
194.02	FOUNDATION SERVICES	194.02
194.03	WELLNESS	194.03

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION

194.04	RENTED SPACE	194.04
200	CROSS FOOT ADJUSTMENTS	200
201	NEGATIVE COST CENTER	201
202	COST TO BE ALLOC PER B PT I	202
203	UNIT COST MULT-WS B PT I	203
204	COST TO BE ALLOC PER B PT II	204
205	UNIT COST MULT-WS B PT II	205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,585,219		3,585,219		3,585,219	30
31 INTENSIVE CARE UNIT	462,889		462,889		462,889	31
43 NURSERY	112,584		112,584		112,584	43
46 OTHER LONG TERM CARE	1,785,371		1,785,371		1,785,371	46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,396,636		2,396,636		2,396,636	50
52 DELIVERY ROOM & LABOR ROOM	247,126		247,126		247,126	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	2,441,338		2,441,338		2,441,338	54
54.01 RADIOLOGY-ULTRASOUND	320,428		320,428		320,428	54.01
60 LABORATORY	2,223,306		2,223,306		2,223,306	60
62 WHOLE BLOOD & PCKD RED BLO	110,711		110,711		110,711	62
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	712,999		712,999		712,999	65
66 PHYSICAL THERAPY	1,432,760		1,432,760		1,432,760	66
69 ELECTROCARDIOLOGY	49,729		49,729		49,729	69
71 MEDICAL SUPPLIES CHRGED TO	1,119,559		1,119,559		1,119,559	71
72 IMPL. DEV. CHARGED TO PATIE	231,082		231,082		231,082	72
73 DRUGS CHARGED TO PATIENTS	2,390,193		2,390,193		2,390,193	73
76 CARDIAC REHAB	126,440		126,440		126,440	76
76.01 OCCUPATIONAL MEDICINE & WEL						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	5,442,320		5,442,320		5,442,320	88
88.01 RHC II	571,370		571,370		571,370	88.01
88.02 RHC III	393,356		393,356		393,356	88.02
90 CLINIC	1,623,471		1,623,471		1,623,471	90
91 EMERGENCY	1,882,557		1,882,557		1,882,557	91
92 OBSERVATION BEDS	268,959		268,959		268,959	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY	781,855		781,855		781,855	101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	30,712,258		30,712,258		30,712,258	200
201 LESS OBSERVATION BEDS	268,959		268,959		268,959	201
202 TOTAL (SEE INSTRUCTIONS)	30,443,299		30,443,299		30,443,299	202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,241,518		2,241,518			30
31 INTENSIVE CARE UNIT	697,122		697,122			31
43 NURSERY	239,862		239,862			43
46 OTHER LONG TERM CARE	928,820		928,820			46
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,586,395	6,425,508	8,011,903	0.299134	0.299134	50
52 DELIVERY ROOM & LABOR ROOM	682,785		682,785	0.361938	0.361938	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	893,396	11,625,242	12,518,638	0.195016	0.195016	54
54.01 RADIOLOGY-ULTRASOUND	270,540	1,884,293	2,154,833	0.148702	0.148702	54.01
60 LABORATORY	1,436,919	10,079,692	11,516,611	0.193052	0.193052	60
62 WHOLE BLOOD & PCKD RED BLOO	120,058	75,078	195,136	0.567353	0.567353	62
62.30 BLOOD CLOTTING FACTORS ADMI						62.30
65 RESPIRATORY THERAPY	395,686	768,881	1,164,567	0.612244	0.612244	65
66 PHYSICAL THERAPY	282,209	2,128,231	2,410,440	0.594398	0.594398	66
OUTPATIENT SERVICE COST CENTERS						
69 ELECTROCARDIOLOGY	84,754	292,634	377,388	0.131772	0.131772	69
71 MEDICAL SUPPLIES CHRGED TO	1,097,974	719,402	1,817,376	0.616030	0.616030	71
72 IMPL. DEV. CHARGED TO PATIE	191,947	206,174	398,121	0.580432	0.580432	72
73 DRUGS CHARGED TO PATIENTS	1,676,053	3,111,636	4,787,689	0.499237	0.499237	73
76 CARDIAC REHAB	312	158,702	159,014	0.795150	0.795150	76
76.01 OCCUPATIONAL MEDICINE & WEL						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
88 RURAL HEALTH CLINIC (RHC)		5,666,314	5,666,314	0.960469	0.960469	88
88.01 RHC II		593,964	593,964	0.961961	0.961961	88.01
88.02 RHC III		530,132	530,132	0.741996	0.741996	88.02
90 CLINIC	6,981	1,012,556	1,019,537	1.592361	1.592361	90
91 EMERGENCY	45,873	3,019,169	3,065,042	0.614203	0.614203	91
92 OBSERVATION BEDS	6,500	286,454	292,954	0.918093	0.918093	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
101 HOME HEALTH AGENCY		764,525	764,525			101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	12,885,704	49,348,587	62,234,291			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	12,885,704	49,348,587	62,234,291			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES DED & COINS	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
		1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.299134		1,801,603			538,921	50	
52 DELIVERY ROOM & LABOR ROOM	0.361938						52	
53 ANESTHESIOLOGY							53	
54 RADIOLOGY-DIAGNOSTIC	0.195016		3,677,916			717,252	54	
54.01 RADIOLOGY-ULTRASOUND	0.148702		565,258			84,055	54.01	
60 LABORATORY	0.193052			4,056,959			60	
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.567353		66,760			37,876	62	
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30	
65 RESPIRATORY THERAPY	0.612244		280,720			171,869	65	
66 PHYSICAL THERAPY	0.594398		722,130			429,233	66	
69 ELECTROCARDIOLOGY	0.131772		223,392			29,437	69	
71 MEDICAL SUPPLIES CHRGED TO PATI	0.616030		182,099			112,178	71	
72 IMPL. DEV. CHARGED TO PATIENT	0.580432		79,921			46,389	72	
73 DRUGS CHARGED TO PATIENTS	0.499237		1,357,344			677,636	73	
76 CARDIAC REHAB	0.795150		28,700			22,821	76	
76.01 OCCUPATIONAL MEDICINE & WELLNES							76.01	
76.97 CARDIAC REHABILITATION							76.97	
76.98 HYPERBARIC OXYGEN THERAPY							76.98	
76.99 LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)	0.960469						88	
88.01 RHC II	0.961961						88.01	
88.02 RHC III	0.741996						88.02	
90 CLINIC	1.592361		316,713			504,321	90	
91 EMERGENCY	0.614203		847,743			520,686	91	
92 OBSERVATION BEDS	0.918093		121,325			111,388	92	
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			10,271,624	4,056,959		4,004,062	783,204	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)			10,271,624	4,056,959		4,004,062	783,204	

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] S/B-SNF (14-Z343)
 APPLICABLE [XX] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES	COST REIMB. SERVICES DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SERVICES DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS	
	1	2	3	4	5	6	7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.299134						50	
52 DELIVERY ROOM & LABOR ROOM	0.361938						52	
53 ANESTHESIOLOGY							53	
54 RADIOLOGY-DIAGNOSTIC	0.195016						54	
54.01 RADIOLOGY-ULTRASOUND	0.148702						54.01	
60 LABORATORY	0.193052						60	
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.567353						62	
62.30 BLOOD CLOTTING FACTORS ADMIN CO							62.30	
65 RESPIRATORY THERAPY	0.612244						65	
66 PHYSICAL THERAPY	0.594398						66	
69 ELECTROCARDIOLOGY	0.131772						69	
71 MEDICAL SUPPLIES CHRGED TO PATI	0.616030						71	
72 IMPL. DEV. CHARGED TO PATIENT	0.580432						72	
73 DRUGS CHARGED TO PATIENTS	0.499237						73	
76 CARDIAC REHAB	0.795150						76	
76.01 OCCUPATIONAL MEDICINE & WELLNES							76.01	
76.97 CARDIAC REHABILITATION							76.97	
76.98 HYPERBARIC OXYGEN THERAPY							76.98	
76.99 LITHOTRIPSY							76.99	
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)	0.960469						88	
88.01 RHC II	0.961961						88.01	
88.02 RHC III	0.741996						88.02	
90 CLINIC	1.592361						90	
91 EMERGENCY	0.614203						91	
92 OBSERVATION BEDS	0.918093						92	
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)							200	
201 LESS PBP CLINIC LAB SERVICES							201	
202 NET CHARGES (LINE 200 - LINE 201)							202	

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM CAP COST (COL.5 x COL.6)
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 + COL.4)		
	1	2	3	4	5	6	7
INPAT ROUTINE SERV COST CTRS							
30 ADULTS & PEDIATRICS							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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-1343) [] IPF [] IRF	[] SUB (OTHER)	[XX] PPS [] TEFRA [] OTHER			
		CAP-REL COST (FROM WKST B, PT. II, COL. 26)	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2)	INPATIENT PROGRAM CHARGES	CAPITAL (COL.3 x COL.4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY-ULTRASOUND						54.01
60	LABORATORY						60
62	WHOLE BLOOD & PCKD RED BLOOD						62
62.30	BLOOD CLOTTING FACTORS ADMIN						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHRGED TO PA						71
72	IMPL. DEV. CHARGED TO PATIENT						72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIAC REHAB						76
76.01	OCCUPATIONAL MEDICINE & WELLN						76.01
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)						88
88.01	RHC II						88.01
88.02	RHC III						88.02
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					30
30 ADULTS & PEDIATRICS					31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII-PT A
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					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 (SUM OF LINES 30-199)					200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK [] TITLE V [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX [] IRF [] NF [] OTHER

COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
52 DELIVERY ROOM & LABOR ROOM						52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
54.01 RADIOLOGY-ULTRASOUND						54.01
60 LABORATORY						60
62 WHOLE BLOOD & PCKD RED BLOOD						62
62.30 BLOOD CLOTTING FACTORS ADMIN						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGD TO PA						71
72 IMPL. DEV. CHARGED TO PATIENT						72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB						76
76.01 OCCUPATIONAL MEDICINE & WELLN						76.01
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC						90
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK	[]	TITLE V	[XX]	HOSPITAL (14-1343)	[]	SUB (OTHER)	[]	ICF/MR	[]	PFS
APPLICABLE	[]	TITLE XVIII-PT A	[]	IPF	[]	SNF			[]	TEFRA
BOXES	[XX]	TITLE XIX	[]	IRF	[]	NF			[]	OTHER
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)			
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50	OPERATING ROOM						50			
52	DELIVERY ROOM & LABOR ROOM						52			
53	ANESTHESIOLOGY						53			
54	RADIOLOGY-DIAGNOSTIC						54			
54.01	RADIOLOGY-ULTRASOUND						54.01			
60	LABORATORY						60			
62	WHOLE BLOOD & PCKD RED BLOOD						62			
62.30	BLOOD CLOTTING FACTORS ADMIN						62.30			
65	RESPIRATORY THERAPY						65			
66	PHYSICAL THERAPY						66			
69	ELECTROCARDIOLOGY						69			
71	MEDICAL SUPPLIES CHRGED TO P						71			
72	IMPL. DEV. CHARGED TO PATIEN						72			
73	DRUGS CHARGED TO PATIENTS						73			
76	CARDIAC REHAB						76			
76.01	OCCUPATIONAL MEDICINE & WELL						76.01			
76.97	CARDIAC REHABILITATION						76.97			
76.98	HYPERBARIC OXYGEN THERAPY						76.98			
76.99	LITHOTRIPSY						76.99			
OUTPATIENT SERVICE COST CENTERS										
88	RURAL HEALTH CLINIC (RHC)						88			
88.01	RHC II						88.01			
88.02	RHC III						88.02			
90	CLINIC						90			
91	EMERGENCY						91			
92	OBSERVATION BEDS						92			
OTHER REIMBURSABLE COST CENTERS										
200	TOTAL (SUM OF LINES 50-199)						200			

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] S/B-SNF
 APPLICABLE [] TITLE XVIII-PT B [] IPF [] SNF [] S/B-NF
 BOXES [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9	PROGRAM CHARGES				PROGRAM COSTS			
		PPS REIMBURSED SERVICES	COST REIMB. SUBJECT TO DED & COINS	COST REIMB. SVCES NOT SUBJECT TO DED & COINS	PPS SERVICES	COST SUBJECT TO DED & COINS	COST SVCES NOT SUBJECT TO DED & COINS		
								2	
ANCILLARY SERVICE COST CENTERS									
50 OPERATING ROOM	0.299134		909,990			272,209		50	
52 DELIVERY ROOM & LABOR ROOM	0.361938							52	
53 ANESTHESIOLOGY								53	
54 RADIOLOGY-DIAGNOSTIC	0.195016		2,958,427			576,941		54	
54.01 RADIOLOGY-ULTRASOUND	0.148702		547,482			81,412		54.01	
60 LABORATORY	0.193052		1,821,261			351,598		60	
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.567353							62	
62.30 BLOOD CLOTTING FACTORS ADMIN CO								62.30	
65 RESPIRATORY THERAPY	0.612244		167,703			102,675		65	
66 PHYSICAL THERAPY	0.594398		289,728			172,214		66	
69 ELECTROCARDIOLOGY	0.131772		46,757			6,161		69	
71 MEDICAL SUPPLIES CHRGED TO PATI	0.616030		141,194			86,980		71	
72 IMPL. DEV. CHARGED TO PATIENT	0.580432							72	
73 DRUGS CHARGED TO PATIENTS	0.499237		75,609			37,747		73	
76 CARDIAC REHAB	0.795150		902			717		76	
76.01 OCCUPATIONAL MEDICINE & WELLNES								76.01	
76.97 CARDIAC REHABILITATION								76.97	
76.98 HYPERBARIC OXYGEN THERAPY								76.98	
76.99 LITHOTRIPSY								76.99	
OUTPATIENT SERVICE COST CENTERS									
88 RURAL HEALTH CLINIC (RHC)	0.960469							88	
88.01 RHC II	0.961961							88.01	
88.02 RHC III	0.741996							88.02	
90 CLINIC	1.592361		158,116			251,778		90	
91 EMERGENCY	0.614203		845,331			519,205		91	
92 OBSERVATION BEDS	0.918093		54,118			49,685		92	
OTHER REIMBURSABLE COST CENTERS									
200 SUBTOTAL (SEE INSTRUCTIONS)			8,016,618			2,509,322		200	
201 LESS PBP CLINIC LAB SERVICES								201	
202 NET CHARGES (LINE 200 - LINE 201)			8,016,618			2,509,322		202	

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,670	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,252	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	119	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,133	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	254	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)	127	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	25	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	12	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,135	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)	254	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)	127	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	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	13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	14	14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	15	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	16	16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	18	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.51	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	123.51	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,585,219	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)	22	22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)	23	23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)	3,013	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	1,482	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	298,958	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,286,261	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,103,625	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	98,301	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,005,324	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 + LINE 28)	1,562,190	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 + LINE 3)	826.06	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 + LINE 4)	485.20	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	340.86	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	532.49	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	63,366	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,222,895	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] TEFRA
 BOXES [] TITLE XIX-INPT [] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 757.97 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 1,618,266 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) 1,618,266 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 + COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 4) 5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT	462,889	125	3,703.11	58	214,780	43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					1,645,228	48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					3,478,274	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 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 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 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 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 INSTRU (TITLE XVIII ONLY) 192,524 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (TITLE XVIII ONLY) 96,262 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 288,786 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) 348 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 772.87 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 268,959 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5	
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST						
90 CAPITAL-RELATED COST	403,271	3,286,261	0.122714	268,959	33,005	90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

WORKSHEET D-1
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] SNF [] TEFRA
 BOXES [XX] TITLE XIX-INPT [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	4,670	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	4,252	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	119	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	4,133	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	254	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)	127	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	25	7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	12	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	518	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	362	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	278	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	120.51	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	123.51	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,585,219	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)	3,013	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	1,482	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	298,958	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,286,261	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,103,625	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	98,301	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,005,324	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1,562,190	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	826.06	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	485.20	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	340.86	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	532.49	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	63,366	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,222,895	37

WORKSHEET D-1
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1343) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEPFA
 BOXES [XX] TITLE XIX-INPT [] IRF [] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 772.87 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 400,347 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) 400,347 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)	112,584	362	311.01	278	86,461 42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43 INTENSIVE CARE UNIT	462,889	125	3,703.11	15	55,547 43
44 CORONARY CARE UNIT					44
45 BURN INTENSIVE CARE UNIT					45
46 SURGICAL INTENSIVE CARE UNIT					46
47 OTHER SPECIAL CARE (SPECIFY)					47
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					605,647 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					1,148,002 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 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 1,148,002 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 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 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 O COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE E 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 INSTRU (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRU (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) 348 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 + LINE 2) 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST	ROUTINE COST (FROM LINE 27)	COL. 1 + COL. 2	TOTAL OBS. BED COST (FROM LINE 89)	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.)
	1	2	3	4	5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST					90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL (14-1343) [] SUB (OTHER) [] S/B SNF [] PPS
 APPLICABLE [XX] TITLE XVIII-PT A [] IPF [] SNF [] S/B NF [] TEFRA
 BOXES [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		1,597,176		30
31 INTENSIVE CARE UNIT		79,634		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.299134	513,686	153,661	50
52 DELIVERY ROOM & LABOR ROOM	0.361938			52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.195016	570,294	111,216	54
54.01 RADIOLOGY-ULTRASOUND	0.148702	179,840	26,743	54.01
60 LABORATORY	0.193052	834,201	161,044	60
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.567353	105,000	59,572	62
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.612244	240,270	147,104	65
66 PHYSICAL THERAPY	0.594398	159,073	94,553	66
69 ELECTROCARDIOLOGY	0.131772	73,467	9,681	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.616030	562,644	346,606	71
72 IMPL. DEV. CHARGED TO PATIENT	0.580432	149,461	86,752	72
73 DRUGS CHARGED TO PATIENTS	0.499237	881,296	439,976	73
76 CARDIAC REHAB	0.795150			76
76.01 OCCUPATIONAL MEDICINE & WELLNES				76.01
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	0.960469			88
88.01 RHC II	0.961961			88.01
88.02 RHC III	0.741996			88.02
90 CLINIC	1.592361	4,734	7,538	90
91 EMERGENCY	0.614203	1,273	782	91
92 OBSERVATION BEDS	0.918093			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,275,239	1,645,228	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,275,239		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) S/B SNF(14-Z343) PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.299134			50
52 DELIVERY ROOM & LABOR ROOM	0.361938			52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.195016	7,635	1,489	54
54.01 RADIOLOGY-ULTRASOUND	0.148702	1,455	216	54.01
60 LABORATORY	0.193052	29,615	5,717	60
62 WHOLE BLOOD & PCKD RED BLOOD CE	0.567353			62
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.612244	27,664	16,937	65
66 PHYSICAL THERAPY	0.594398	96,147	57,150	66
69 ELECTROCARDIOLOGY	0.131772	183	24	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.616030	34,671	21,358	71
72 IMPL. DEV. CHARGED TO PATIENT	0.580432			72
73 DRUGS CHARGED TO PATIENTS	0.499237	76,565	38,224	73
76 CARDIAC REHAB	0.795150			76
76.01 OCCUPATIONAL MEDICINE & WELLNES				76.01
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	0.960469			88
88.01 RHC II	0.961961			88.01
88.02 RHC III	0.741996			88.02
90 CLINIC	1.592361	58	92	90
91 EMERGENCY	0.614203			91
92 OBSERVATION BEDS	0.918093			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		273,993	141,207	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		273,993		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL (14-1343) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEPRA
 BOXES TITLE XIX IRF NF ICF/MR OTHER

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		422,513		30
31 INTENSIVE CARE UNIT		20,595		31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.299134	384,697	115,076	50
52 DELIVERY ROOM & LABOR ROOM	0.361938	364,920	132,078	52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.195016	219,585	42,823	54
54.01 RADIOLOGY-ULTRASOUND	0.148702	36,174	5,379	54.01
60 LABORATORY	0.193052	258,158	49,838	60
62 WHOLE BLOOD & PKCD RED BLOOD CE	0.567353			62
62.30 BLOOD CLOTTING FACTORS ADMIN CO				62.30
65 RESPIRATORY THERAPY	0.612244	63,830	39,080	65
66 PHYSICAL THERAPY	0.594398	12,686	7,541	66
69 ELECTROCARDIOLOGY	0.131772	6,510	858	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.616030	110,855	68,290	71
72 IMPL. DEV. CHARGED TO PATIENT	0.580432			72
73 DRUGS CHARGED TO PATIENTS	0.499237	234,636	117,139	73
76 CARDIAC REHAB	0.795150			76
76.01 OCCUPATIONAL MEDICINE & WELLNES				76.01
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	0.960469			88
88.01 RHC II	0.961961			88.01
88.02 RHC III	0.741996			88.02
90 CLINIC	1.592361	280	446	90
91 EMERGENCY	0.614203	34,628	21,269	91
92 OBSERVATION BEDS	0.918093	6,350	5,830	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,733,309	605,647	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,733,309		202

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK HOSPITAL (14-1343) SUB (OTHER)
 APPLICABLE IPF SNF
 BOX: IRF SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	PART I	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,216,126		2,559,677	1	
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2	
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 11/19/2010	198,387	11/13/2009	223,072	3.01	
	.02 05/15/2011	78,202	05/15/2011	9,808	3.02	
	PROGRAM .03				3.03	
	TO .04				3.04	
	PROVIDER .05				3.05	
	.06				3.06	
	.07				3.07	
	.08				3.08	
	.09				3.09	
	.50	NONE		NONE	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	
	.99	276,589		232,880	3.99	
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)						
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		3,492,715		2,792,557	4	

TO BE COMPLETED BY CONTRACTOR

5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01	NONE		NONE	5.01	
	TO .02				5.02	
	PROVIDER .03				5.03	
	.04				5.04	
	.05				5.05	
	.06				5.06	
	.07				5.07	
	.08				5.08	
	.09				5.09	
	PROVIDER .50	NONE		NONE	5.50	
	TO .51				5.51	
	PROGRAM .52				5.52	
	.53				5.53	
	.54				5.54	
	.55				5.55	
	.56				5.56	
	.57				5.57	
	.58				5.58	
	.59				5.59	
	.99				5.99	
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM TO .01			372,298	6.01	
	PROVIDER TO .02	-348,371			6.02	
	PROGRAM					
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		3,144,344		3,164,855	7	

8 NAME OF CONTRACTOR: _____ CONTRACTOR NUMBER: _____ DATE: _____

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [] SNF [XX] SWING BED SNF (14-Z343)	INPATIENT		PART B	
			MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4
DESCRIPTION						
1				376,407		1
2				NONE		2
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.						
3		.01	11/19/2010	21,125		3.01
		.02	05/15/2011	10,647		3.02
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.50		NONE		3.50
		.51				3.51
		.52				3.52
		.53				3.53
		.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
		.99		31,772		3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)						
4				408,179		4
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)						
TO BE COMPLETED BY CONTRACTOR						
5		.01		NONE		5.01
		.02				5.02
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.50		NONE		5.50
		.51				5.51
		.52				5.52
		.53				5.53
		.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
		.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)						
6		.01		24,165		6.01
		.02				6.02
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT						
7				432,344		7
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)						
8	NAME OF CONTRACTOR:			CONTRACTOR NUMBER:	DATE:	

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/23/2011 13:04

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL (14-1343) CAH
APPLICABLE BOX

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,150 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,193 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	4,029 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	62,234,291 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	1,688,313 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	7 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	8 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	30 30
31	OTHER ADJUSTMENTS (SPECIFY)	31 31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	32 32

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF (14-Z343)
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES [] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A 1	PART B 2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	291,674	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	142,619	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	381	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	434,293	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	434,293	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	434,293	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	1,949	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)	432,344	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	432,344	19
20 INTERIM PAYMENTS	408,179	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	24,165	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

CHECK [XX] HOSPITAL (14-1343)
APPLICABLE BOX: [] SUB (OTHER)

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

1	INPATIENT SERVICES	3,478,274	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	3,478,274	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (LINE 5 LESS LINE 6) (FOR CAH, SEE INSTRUCTIONS)	3,513,057	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES	4,275,239	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)		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 INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	3,513,057	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	438,414	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	3,074,643	22
23	COINSURANCE		23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	3,074,643	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	69,701	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	69,701	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	42,555	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26 (LINE 26 HOSPITAL AND SUBPROVIDER ONLY))	3,144,344	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	3,144,344	30
31	INTERIM PAYMENTS	3,492,715	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-348,371	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK [] TITLE V [XX] HOSPITAL (14-1343) [] SNF [XX] PPS
 APPLICABLE [XX] TITLE XIX [] IPF [] NF [] TEFRA
 BOXES: [] IRF [] ICF/MR [] OTHER
 [] SUB (OTHER)

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

COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES		1
2	MEDICAL AND OTHER SERVICES	2,509,322	2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	2,509,322	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	2,509,322	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	443,108	8
9	ANCILLARY SERVICE CHARGES	9,749,927	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)		15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 7 (SEE INSTRUCTIONS))		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 7 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LINE 7)	2,509,322	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 22-26)		27
28	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		28
29	TITLE V OR XIX PPS, LESSER OF LINES 27 OR 28, NON-PPS ENTER AMOUNT FROM LINE 27		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (FROM LINE 18)		30
31	SUBTOTAL (SUM OF LINES 19-21 MINUS 29)	2,509,322	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)	2,509,322	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)	2,509,322	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)	2,509,322	40
41	INTERIM PAYMENTS	2,509,322	41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)		42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET E-4

CHECK [] TITLE V
 APPLICABLE [XX] TITLE XVIII
 BOX: [] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
		PRIMARY CARE 1	OTHER 2	TOTAL 3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR			8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6			9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT			11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)			12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)			13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)			14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT			17
18	PER RESIDENT AMOUNT			18
19	APPROVED AMOUNT FOR RESIDENT COSTS			19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			25
	COMPUTATION OF PROGRAM PATIENT LOAD	INPATIENT PART A	MANAGED CARE	
26	INPATIENT DAYS	2,193		26
27	TOTAL INPATIENT DAYS	4,029		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS			28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR NURSING/ALLIED HEALTH			30
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)			
31	NET PROGRAM DIRECT GME AMOUNT			31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 + LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
	APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			
	PART A REASONABLE COST			
37	REASONABLE COST (SEE INSTRUCTIONS)		3,769,948	37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			41
	PART B REASONABLE COST			
42	REASONABLE COST (SEE INSTRUCTIONS)		1,433,703	42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 + LINE 45)			46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 + LINE 45)			47
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			50

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

WORKSHEET B-4

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII
 BOX: [XX] TITLE XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR COST REPORTING PERIODS ENDING ON OR BEFORE DECEMBER 31, 1996			1
2	UNWEIGHTED FTE RESIDENT CAP ADD-ON FOR NEW PROGRAMS PER 42 CFR 413.79(e)(1) (SEE INSTRUCTIONS)			2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 422 OF MMA			3
3.01	DIRECT GME CAP REDUCTION AMOUNT UNDER ACA §5503 IN ACCORDANCE WITH CFR §413.79(m). (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			3.01
4	ADJUSTMENT (PLUS OR MINUS) TO THE FTE CAP FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS DUE TO A MEDICARE GME AFFILIATION AGREEMENT (42 CFR §413.75(b) AND §413.79(f))			4
4.01	ACA SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.01
4.02	ACA SECTION 5506 NUMBER OF ADDITIONAL DIRECT GME FTE CAP SLOTS (SEE INSTRUCTIONS FOR COST REPORTING PERIODS STRADDLING 7/1/2011)			4.02
5	FTE ADJUSTMENT CAP (LINE 1 PLUS LINE 2 MINUS LINE 3 AND 3.01 PLUS OR MINUS LINE 4 PLUS LINE 4.01 PLUS LINE 4.02 PLUS APPLICABLE SUBSCRIPTS)			5
6	UNWEIGHTED RESIDENT FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE CURRENT YEAR FROM YOUR RECORDS (SEE INSTRUCTIONS)			6
7	ENTER THE LESSER OF LINE 5 OR LINE 6			7
		PRIMARY CARE	OTHER	TOTAL
		1	2	3
8	WEIGHTED FTE COUNT FOR PHYSICIANS IN AN ALLOPATHIC AND OSTEOPATHIC PROGRAM FOR THE CURRENT YEAR			8
9	IF LINE 6 IS LESS THAN LINE 5 ENTER THE AMOUNT FROM LINE 8, OTHERWISE MULTIPLY LINE 8 TIMES THE RESULT OF LINE 5 DIVIDED BY THE AMOUNT ON LINE 6			9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR			10
11	TOTAL WEIGHTED FTE COUNT			11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (SEE INSTRUCTIONS)			12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (SEE INSTRUCTIONS)			13
14	ROLLING AVERAGE FTE COUNT (SUM OF LINES 11-13 DIVIDED BY 3)			14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS			15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE			16
17	ADJUSTED ROLLING AVERAGE FTE COUNT			17
18	PER RESIDENT AMOUNT			18
19	APPROVED AMOUNT FOR RESIDENT COSTS			19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)			20
21	GME FTE WEIGHTED RESIDENT COUNT OVER CAP (SEE INSTRUCTIONS)			21
22	ALLOWABLE ADDITIONAL DIRECT GME FTE RESIDENT COUNT (SEE INSTRUCTIONS)			22
23	ENTER THE LOCALITY ADJUSTMENT NATIONAL AVERAGE PER RESIDENT AMOUNT (SEE INSTRUCTIONS)			23
24	MULTIPLY LINE 22 TIMES LINE 23			24
25	TOTAL DIRECT GME AMOUNT (SUM OF LINES 19 AND 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD		INPATIENT	MANAGED	
		PART A	CARE	
26	INPATIENT DAYS	533		26
27	TOTAL INPATIENT DAYS	4,029		27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS			28
29	PROGRAM DIRECT GME AMOUNT			29
30	REDUCTION FOR NURSING/ALLIED HEALTH			30
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
31	NET PROGRAM DIRECT GME AMOUNT			31
32	RENAL DIALYSIS DIRECT MEDICAL EDUCATION COSTS (FROM WKST B, PART I, SUM OF COLS. 20 AND 23, LINES 74 AND 94)			32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (WKST C, PART I, COL. 8, SUM OF LINES 74 AND 94)			33
34	RATIO OF DIRECT MEDICAL EDUCATION COSTS TO TOTAL CHARGES (LINE 32 + LINE 33)			34
35	MEDICARE OUTPATIENT ESRD CHARGES (SEE INSTRUCTIONS)			35
36	MEDICARE OUTPATIENT ESRD DIRECT MEDICAL EDUCATION COSTS (LINE 34 x LINE 35)			36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME				
PART A REASONABLE COST				
37	REASONABLE COST (SEE INSTRUCTIONS)			37
38	ORGAN ACQUISITION COSTS (WKST D-4, PART III, COL. 1, LINE 69)			38
39	COST OF TEACHING PHYSICIANS (WKST D-5, PART II, COL. 3, LINE 20)			39
40	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			40
41	TOTAL PART A REASONABLE COST (SUM OF LINES 37-39 MINUS LINE 40)			41
PART B REASONABLE COST				
42	REASONABLE COST (SEE INSTRUCTIONS)			42
43	PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)			43
44	TOTAL PART B REASONABLE COST (LINE 42 MINUS LINE 43)			44
45	TOTAL REASONABLE COST (SUM OF LINES 41 AND 44)			45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (LINE 41 + LINE 45)			46
47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (LINE 44 + LINE 45)			47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48	TOTAL PROGRAM GME PAYMENT (LINE 31)			48
49	PART A MEDICARE GME PAYMENT (LINE 46 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			49
50	PART B MEDICARE GME PAYMENT (LINE 47 x LINE 48) (TITLE XVIII ONLY) (SEE INSTRUCTIONS)			50

BALANCE SHEET

WORKSHEET G

ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT ASSETS				
1 CASH ON HAND AND IN BANKS	6,319,844			1
2 TEMPORARY INVESTMENTS	1,137,003			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	5,980,546			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE				6
7 INVENTORY	749,806			7
8 PREPAID EXPENSES	628,058			8
9 OTHER CURRENT ASSETS	209,181			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	15,024,438			11
FIXED ASSETS				
12 LAND	48,365			12
13 LAND IMPROVEMENTS	1,485,155			13
14 ACCUMULATED DEPRECIATION	-672,972			14
15 BUILDINGS	35,040,091			15
16 ACCUMULATED DEPRECIATION	-13,585,994			16
17 LEASEHOLD IMPROVEMENTS				17
18 ACCUMULATED AMORTIZATION				18
19 FIXED EQUIPMENT				19
20 ACCUMULATED DEPRECIATION				20
21 AUTOMOBILES AND TRUCKS				21
22 ACCUMULATED DEPRECIATION				22
23 MAJOR MOVABLE EQUIPMENT	10,377,734			23
24 ACCUMULATED DEPRECIATION	-6,850,875			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS				27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	25,841,504			30
OTHER ASSETS				
31 INVESTMENTS	11,335,241			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	341,172			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	11,676,413			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	52,542,355			36
LIABILITIES AND FUND BALANCES	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	804,568			37
38 SALARIES, WAGES & FEES PAYABLE	2,068,405			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	806,173			40
41 DEFERRED INCOME				41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	2,403,806			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	6,082,952			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	13,237,803			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES				49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	13,237,803			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	19,320,755			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	33,221,600			52
53 SPECIFIC PURPOSE FUND BALANCE				53
54 DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55 DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56 GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57 PLANT FUND BALANCE - INVESTED IN PLANT				57
58 PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59 TOTAL FUND BALANCES (SUM OF LINES 52-58)	33,221,600			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	52,542,355			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		30,733,384							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		2,488,216							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		33,221,600							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		33,221,600							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		33,221,600							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	1,908,418		1,908,418	1
2 SUBPROVIDER IPF				2
3 SUBPROVIDER IRF				3
5 SWING BED - SNF	137,994		137,994	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,046,412		2,046,412	10
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11 INTENSIVE CARE UNIT	696,685		696,685	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)	696,685		696,685	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,743,097		2,743,097	17
18 ANCILLARY SERVICES	9,861,674	42,526,678	52,388,352	18
19 OUTPATIENT SERVICES		5,798,145	5,798,145	19
20 RHC		5,481,387	5,481,387	20
20.01 RHC II		843,290	843,290	20.01
20.02 RHC III		702,742	702,742	20.02
21 FQHC				21
22 HOME HEALTH AGENCY		764,524	764,524	22
23 AMBULANCE				23
25 ASC				25
26 HOSPICE				26
27 PHYSICIAN PRIVATE OFFICE		179,588	179,588	27
27.01 LONG TERM CARE		931,200	931,200	27.01
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	12,604,771	57,227,554	69,832,325	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		38,216,567	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		38,216,567	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION

1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	69,832,325	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	30,492,201	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	39,340,124	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	38,216,567	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	1,123,557	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	130,346	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		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	154,247	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	38,615	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	109,494	22
23	GOVERNMENTAL APPROPRIATIONS	491,887	23
24	OTHER (CONSULTING CLINIC)	55,700	24
24.01	OTHER (WELLNESS)	94,141	24.01
24.02	OTHER (GRANTS)	52,266	24.02
24.03	OTHER (OTHER PROFESSIONAL INCOME)	150,496	24.03
24.04	OTHER (FOUNDATION REIMBURSEMENT)	15,339	24.04
24.05	OTHER (DONATIONS)	30,173	24.05
24.06	OTHER (OTHER INCOME)	41,955	24.06
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,364,659	25
26	TOTAL (LINE 5 PLUS LINE 25)	2,488,216	26
27	OTHER EXPENSES (LOSS ON SALE OF ASSET)		27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)		28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	2,488,216	29

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7175

WORKSHEET H

	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR- TATION (SEE INSTR.) 3	CONTRACTED/ PURCHASED SERVICES 4	OTHER COSTS 5	TOTAL (SUM OF (COLS.1-5) 6
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED-BLDGS & FIXTURES						1
2 CAPITAL RELATED-MOVABLE EQUIPMENT						2
3 PLANT OPERATION & MAINTENANCE						3
4 TRANSPORTATION (SEE INSTRUCTIONS)						4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	104,584	6,035	1,954	28,561	36,545	177,679
6 SKILLED NURSING CARE	229,712	14,931	18,313			262,956
7 PHYSICAL THERAPY	39,450	2,564	5,894			47,908
8 OCCUPATIONAL THERAPY	4,687	305	1,329			6,321
9 SPEECH PATHOLOGY				2,530		2,530
10 MEDICAL SOCIAL SERVICES				480		480
11 HOME HEALTH AIDE	38,498	2,502	9,394			50,394
12 SUPPLIES (SEE INSTRUCTIONS)						12
13 DRUGS						13
14 DME						14
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SERVICES						15
16 RESPIRATORY THERAPY						16
17 PRIVATE DUTY NURSING						17
18 CLINIC						18
19 HEALTH PROMOTION ACTIVITIES						19
20 DAY CARE PROGRAM						20
21 HOME DELIVERED MEALS PROGRAM						21
22 HOMEMAKER SERVICE						22
23 ALL OTHERS						23
24 TOTAL (SUM OF LINES 1-23)	416,931	26,337	36,884	31,571	36,545	548,268

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7175

WORKSHEET H
 (CONTINUED)

	RECLASS- IFICATIONS 7	RECLASSIFIED TRIAL BALANCE (COL.6 + COL.7) 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION (COL.8 + COL.9) 10	
1					1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
GENERAL SERVICE COST CENTER					
CAPITAL RELATED-BLDGS & FIXTURES					
CAPITAL RELATED-MOVABLE EQUIPMENT					
PLANT OPERATION & MAINTENANCE					
TRANSPORTATION (SEE INSTRUCTIONS)					
ADMINISTRATIVE AND GENERAL	-8,162	169,517	-32,123	137,394	
HHA REIMBURSABLE SERVICES					
SKILLED NURSING CARE		262,956		262,956	
PHYSICAL THERAPY		47,908		47,908	
OCCUPATIONAL THERAPY		6,321		6,321	
SPEECH PATHOLOGY		2,530		2,530	
MEDICAL SOCIAL SERVICES		480		480	
HOME HEALTH AIDE		50,394		50,394	
SUPPLIES (SEE INSTRUCTIONS)					
DRUGS					
DME					
HHA NONREIMBURSABLE SERVICES					
HOME DIALYSIS AIDE SERVICES					
RESPIRATORY THERAPY					
PRIVATE DUTY NURSING					
CLINIC					
HEALTH PROMOTION ACTIVITIES					
DAY CARE PROGRAM					
HOME DELIVERED MEALS PROGRAM					
HOMEMAKER SERVICE					
ALL OTHERS					
TOTAL (SUM OF LINES 1-23)	-8,162	540,106	-32,123	507,983	

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7175

WORKSHEET H-1
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL COSTS BLDG & FIXTURES	CAP REL COSTS MVBL EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL (COLS. 0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS. 4A+5) 6	
	0	1	2	3	4	4A	5	6	
GENERAL SERVICE COST CENTER									
1 CAPITAL RELATED-BLDGS & FIXT									1
2 CAPITAL RELATED-MOVABLE EQUIP									2
3 PLANT OPERATION & MAINTENANCE									3
4 TRANSPORTATION (SEE INSTR.)									4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	137,394					137,394	137,394		5
6 SKILLED NURSING CARE	262,956					262,956	97,490	360,446	6
7 PHYSICAL THERAPY	47,908					47,908	17,762	65,670	7
8 OCCUPATIONAL THERAPY	6,321					6,321	2,343	8,664	8
9 SPEECH PATHOLOGY	2,530					2,530	938	3,468	9
10 MEDICAL SOCIAL SERVICES	480					480	178	658	10
11 HOME HEALTH AIDE	50,394					50,394	18,683	69,077	11
12 SUPPLIES (SEE INSTRUCTIONS)									12
13 DRUGS									13
14 DME									14
HHA NONREIMBURSABLE SERVICES									
15 HOME DIALYSIS AIDE SERVICES									15
16 RESPIRATORY THERAPY									16
17 PRIVATE DUTY NURSING									17
18 CLINIC									18
19 HEALTH PROMOTION ACTIVITIES									19
20 DAY CARE PROGRAM									20
21 HOME DELIVERED MEALS PROGRAM									21
22 HOMEMAKER SERVICE									22
23 ALL OTHERS									23
24 TOTAL (SUM OF LINES 1-23)	507,983					507,983		507,983	24

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET)	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE)	PLANT OPERATN & MAINT (SQUARE FEET)	TRANSPORT- ATION (MILEAGE)	RECONCIL- IATION	ADMIN & GENERAL (ACCUM COST)	
	1	2	3	4	5A	5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDGS & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION (SEE INSTR.)							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-137,394	370,589	5
6 SKILLED NURSING CARE						262,956	6
7 PHYSICAL THERAPY						47,908	7
8 OCCUPATIONAL THERAPY						6,321	8
9 SPEECH PATHOLOGY						2,530	9
10 MEDICAL SOCIAL SERVICES						480	10
11 HOME HEALTH AIDE						50,394	11
12 SUPPLIES (SEE INSTRUCTIONS)							12
13 DRUGS							13
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING							17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL (SUM OF LINES 1-23)					-137,394	370,589	24
25 COST TO BE ALLOC (PER W/S H)						137,394	25
26 UNIT COST MULTIPLIER						0.370745	26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	ALLOCATED		TOTAL HHA COSTS	
	HHA A&G (SEE PT.2) 27			
1 ADMINISTRATIVE AND GENERAL				1
2 SKILLED NURSING CARE	109,029		557,023	2
3 PHYSICAL THERAPY	19,733		100,817	3
4 OCCUPATIONAL THERAPY	2,575		13,157	4
5 SPEECH PATHOLOGY	929		4,745	5
6 MEDICAL SOCIAL SERVICES	176		900	6
7 HOME HEALTH AIDE	20,594		105,213	7
8 SUPPLIES				8
9 DRUGS				9
10 DME				10
11 HOME DIALYSIS AIDE SERVICES				11
12 RESPIRATORY THERAPY				12
13 PRIVATE DUTY NURSING				13
14 CLINIC				14
15 HEALTH PROMOTION ACTIVITIES				15
16 DAY CARE PROGRAM				16
17 HOME DELIVERED MEALS PROGRAM				17
18 HOMEMAKER SERVICE				18
19 ALL OTHERS				19
20 TOTAL (SUM OF LINES 1-19)	153,036		781,855	20
21 UNIT COST MULTIPLIER: COL. 26, LINE 1 DIVIDED BY THE SUM OF COL. 26, LINE 20 MINUS COL. 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.	0.243371			21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-2
 PART II

HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	OTHER CAP REL COSTS NOT USED	EMPLOYEE BENEFITS GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	ADMITTING INPATIENT REVENUE
	1	2	3	4	5.01	5.02	5.03	5.04
1 ADMINISTRATIVE AND GENERAL		8,314		104,584	15		5	
2 SKILLED NURSING CARE				229,712				
3 PHYSICAL THERAPY				39,450				
4 OCCUPATIONAL THERAPY				4,687				
5 SPEECH PATHOLOGY								
6 MEDICAL SOCIAL SERVICES								
7 HOME HEALTH AIDE				38,498				
8 SUPPLIES								
9 DRUGS								
10 DME								
11 HOME DIALYSIS AIDE SERVICES								
12 RESPIRATORY THERAPY								
13 PRIVATE DUTY NURSING								
14 CLINIC								
15 HEALTH PROMOTION ACTIVITIES								
16 DAY CARE PROGRAM								
17 HOME DELIVERED MEALS PROGRAM								
18 HOMEMAKER SERVICE								
19 ALL OTHERS								
19.50 TELEMEDICINE								
20 TOTAL (SUM OF LINES 1-19)		8,314		416,931	15		5	
21 TOTAL COST TO BE ALLOCATED		8,335		84,778	1,645		1,042	
22 UNIT COST MULTIPLIER				109.666667			208.400000	
22 UNIT COST MULTIPLIER		1.002526		0.203338				

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-2
 PART II

HHA COST CENTER	NURSING	I&R	I&R	PARAMED	
	SCHOOL	SALARY & FRINGES	PROGRAM COSTS	EDUCATION	
	ASSIGNED TIME	ASSIGNED TIME	ASSIGNED TIME	ASSIGNED TIME	
	20	21	22	23	
1 ADMINISTRATIVE AND GENERAL					1
2 SKILLED NURSING CARE					2
3 PHYSICAL THERAPY					3
4 OCCUPATIONAL THERAPY					4
5 SPEECH PATHOLOGY					5
6 MEDICAL SOCIAL SERVICES					6
7 HOME HEALTH AIDE					7
8 SUPPLIES					8
9 DRUGS					9
10 DME					10
11 HOME DIALYSIS AIDE SERVICES					11
12 RESPIRATORY THERAPY					12
13 PRIVATE DUTY NURSING					13
14 CLINIC					14
15 HEALTH PROMOTION ACTIVITIES					15
16 DAY CARE PROGRAM					16
17 HOME DELIVERED MEALS PROGRAM					17
18 HOMEMAKER SERVICE					18
19 ALL OTHERS					19
19.50 TELEMEDICINE					19.50
20 TOTAL (SUM OF LINES 1-19)					20
21 TOTAL COST TO BE ALLOCATED					21
22 UNIT COST MULTIPLIER					22
22 UNIT COST MULTIPLIER					22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7175

WORKSHEET H-3
 PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	
PATIENT SERVICES		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)		(COL.3 + COL.4)	
		2	1	2	3	4	5	
1	SKILLED NURSING CARE		557,023		557,023	4,454	125.06	1
2	PHYSICAL THERAPY		100,817		100,817	901	111.89	2
3	OCCUPATIONAL THERAPY		13,157		13,157	246	53.48	3
4	SPEECH PATHOLOGY		4,745		4,745	46	103.15	4
5	MEDICAL SOCIAL SERVICES		900		900	6	150.00	5
6	HOME HEALTH AIDE		105,213		105,213	643	163.63	6
7	TOTAL (SUM OF LINES 1-6)		781,855		781,855	6,296		7

PATIENT SERVICES

8	SKILLED NURSING CARE							8
9	PHYSICAL THERAPY							9
10	OCCUPATIONAL THERAPY							10
11	SPEECH PATHOLOGY							11
12	MEDICAL SOCIAL SERVICES							12
13	HOME HEALTH AIDE							13
14	TOTAL (SUM OF LINES 8-13)							14

SUPPLIES AND DRUGS COST COMPUTATIONS

OTHER PATIENT SERVICES		FROM	FACILITY COSTS	SHARED ANCILLARY COSTS	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	
		WKST H-2, PART I, COL 28, LINE	(FROM WKST H-2, PART I)	(FROM PART II)	COLS. 1+2)	(FROM HHA RECORD)	(COL.3 + COL.4)	
		8	1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES			7,291	7,291	11,836	0.616002	15
16	COST OF DRUGS							16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7175

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

CHECK APPLICABLE BOX: [] TITLE V [] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION	PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (SUM OF COLS.9-10)
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
PATIENT SERVICES	6	7	8	9	10	11	12
1 SKILLED NURSING CARE	1,236	1,109		154,574	138,692		293,266
2 PHYSICAL THERAPY	525	171		58,742	19,133		77,875
3 OCCUPATIONAL THERAPY	117	47		6,257	2,514		8,771
4 SPEECH PATHOLOGY	23	2		2,372	206		2,578
5 MEDICAL SOCIAL SERVICES		2			300		300
6 HOME HEALTH AIDE	379	234		62,016	38,289		100,305
7 TOTAL (SUM OF LINES 1-6)	2,280	1,565		283,961	199,134		483,095

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		TOTAL
		PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	1	2	3	4
9 PHYSICAL THERAPY	99914	1,236	1,109	8
10 OCCUPATIONAL THERAPY	99914	525	171	9
11 SPEECH PATHOLOGY	99914	117	47	10
12 MEDICAL SOCIAL SERVICES	99914	23	2	11
13 HOME HEALTH AIDE	99914		2	12
14 TOTAL (SUM OF LINES 8-13)	99914	379	234	13
		2,280	1,565	14

SUPPLIES AND DRUGS COST COMPUTATIONS	PROGRAM COVERED CHARGES			COST OF SERVICES			
	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	PART A	NOT SUBJ TO DEDUCTIBLES & COINSUR	SUBJECT TO DEDUCTIBLES & COINSUR	
OTHER PATIENT SERVICES	6	7	8	9	10	11	
15 COST OF MEDICAL SUPPLIES	2,986	4,195		1,839	2,584		15
16 COST OF DRUGS							16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

FROM WKST C, PART I, COL.9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (FROM PROVIDER RECORDS)	HHA SHARED ANCILLARY COSTS (COL.1 x COL.2)	TRANSFER TO PART I AS INDICATED
1 PHYSICAL THERAPY	66	0.594398		COL 2, LINE 2
2 OCCUPATIONAL THERAPY	67			COL 2, LINE 3
3 SPEECH PATHOLOGY	68			COL 2, LINE 4
4 MEDICAL SUPPLIES CHRGD TO PAT	71	0.616030	11,836	7,291
5 DRUGS CHARGED TO PATIENTS	73	0.499237		COL 2, LINE 15
				COL 2, LINE 16

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA NO.: 14-7175

WORKSHEET H-4
 PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

DESCRIPTION	PART A 1	----- PART B -----	
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3
1 REASONABLE COST OF PART A & PART B SERVICES			1
2 REASONABLE COST OF SERVICES (SEE INSTRUCTIONS)			2
3 TOTAL CHARGES	280,452		2
CUSTOMARY CHARGES			
4 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (FROM YOUR RECORDS)			3
5 AMOUNT 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(B)			4
6 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)			5
7 TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	280,452		6
8 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 1)	280,452		7
9 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 6)			8
10 PRIMARY PAYER PAYMENTS			9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES		PART B SERVICES
	1	2	
11 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	280,452	174,992	11
13 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	5,843	4,892	12
14 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	4,196	3,718	13
15 TOTAL PPS REIMBURSEMENT - PEP EPISODES	449		14
16 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	5,683	2,937	15
17 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
18 TOTAL OTHER PAYMENTS			17
19 DME PAYMENTS			18
20 OXYGEN PAYMENTS			19
21 PROSTHETIC AND ORTHOTIC PAYMENTS			20
22 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
23 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	296,623	186,539	22
24 EXCESS REASONABLE COST (FROM LINE 8)			23
25 SUBTOTAL (LINE 22 MINUS LINE 23)	296,623	186,539	24
26 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
27 NET COST (LINE 24 MINUS LINE 25)	296,623	186,539	26
28 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
29 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
30 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	296,623	186,539	29
31 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
32 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	296,623	186,539	31
33 INTERIM PAYMENTS (SEE INSTRUCTIONS)	296,623	186,539	32
34 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
35 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7175

WORKSHEET H-5

DESCRIPTION	PART A		PART B	
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		296,623		186,539
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59 3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		296,623		186,539
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 .02 .03 .04 .05 .06 .07 .08 .09 .50 .51 .52 .53 .54 .55 .56 .57 .58 .59 .99	NONE		5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59 5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.)	PROGRAM TO PROVIDER PROVIDER TO PROGRAM	.01 .02		6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		296,623		186,539
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		DATE:

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL [XX] PPS
APPLICABLE [] TITLE XVIII-PT A [] SUB (OTHER) [] COST METHOD
BOXES [XX] TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT	1
2	CAPITAL DRG OTHER THAN OUTLIER	2
3	CAPITAL DRG OUTLIER PAYMENTS	3
4	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	4
5	NUMBER OF INTERNS & RESIDENTS (SEE INSTRUCTIONS)	5
6	INDIRECT MEDICAL EDUCATION PERCENTAGE (SEE INSTRUCTIONS)	6
7	INDIRECT MEDICAL EDUCATION ADJUSTMENT (LINE 1 TIMES LINE 5)	7
8	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (WKST E, PART A, LINE 30) (SEE INSTRUCTIONS)	8
9	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	9
10	SUM OF LINES 7 AND 8	10
11	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	11
12	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	12
13	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	13

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (SEE INSTRUCTIONS)	2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 1 PLUS LINE 2)	3
4	CAPITAL COST PAYMENT FACTOR (SEE INSTRUCTIONS)	4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (LINE 3 TIMES LINE 4)	5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (SEE INSTRUCTIONS)	1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	2
3	NET PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (LINE 1 MINUS LINE 2)	3
4	APPLICABLE EXCEPTION PERCENTAGE (SEE INSTRUCTIONS)	4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (LINE 3 TIMES LINE 4)	5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (SEE INSTRUCTIONS)	6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 2 TIMES LINE 6)	7
8	CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (LINE 5 PLUS LINE 7)	8
9	CURRENT YEAR CAPITAL PAYMENTS (FROM PART I, LINE 12 AS APPLICABLE)	9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 8 LESS LINE 9)	10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (FROM PRIOR YEAR WKST L, PART III, LINE 14)	11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (LINE 10 PLUS LINE 11)	12
13	CURRENT YEAR EXCEPTION PAYMENT (IF LINE 12 IS POSITIVE, ENTER THE AMOUNT ON THIS LINE)	13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (IF LINE 12 IS NEGATIVE, ENTER THE AMOUNT ON THIS LINE)	14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)	15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)	16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (SEE INSTRUCTIONS)	17

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS 0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 NONPATIENT TELEPHONES					5.01
5.02 DATA PROCESSING					5.02
5.03 PURCHASING RECEIVING AND STORE					5.03
5.04 ADMITTING					5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE					5.05
5.06 OTHER ADMINISTRATIVE AND GENER					5.06
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 SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
43 NURSERY					43
46 OTHER LONG TERM CARE					46
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
52 DELIVERY ROOM & LABOR ROOM					52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
54.01 RADIOLOGY-ULTRASOUND					54.01
60 LABORATORY					60
62 WHOLE BLOOD & PCKD RED BLOOD C					62
62.30 BLOOD CLOTTING FACTORS ADMIN C					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIAC REHAB					76
76.01 OCCUPATIONAL MEDICINE & WELLNE					76.01
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC (RHC)					88
88.01 RHC II					88.01
88.02 RHC III					88.02
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
101 HOME HEALTH AGENCY					101
SPECIAL PURPOSE COST CENTERS					
113 INTEREST EXPENSE					113
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
194 NONREIMBURSEABLE					194
194.01 PROFESSIONAL BUILDINGS					194.01
194.02 FOUNDATION SERVICES					194.02
194.03 WELLNESS					194.03

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
11/23/2011 13:04

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	0	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26	
194.04 RENTED SPACE							194.04
200 CROSS FOOT ADJUSTMENTS							200
201 NEGATIVE COST CENTER							201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)							202
203 TOTAL STATISTICAL BASIS							203
204 UNIT COST MULTIPLIER							204
204 UNIT COST MULTIPLIER							204

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

RHC I
 COMPONENT NO: 14-3429

WORKSHEET M-1

CHECK APPLICABLE BOX [XX] RHC [] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN	1,857,011		1,857,011		1,857,011		1,857,011	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	46,804		46,804		46,804		46,804	3
4 VISITING NURSE								4
5 OTHER NURSE								5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS	583,372	318,063	901,435		901,435		901,435	9
10 SUBTOTAL (SUM OF LINES 1-9)	2,487,187	318,063	2,805,250		2,805,250		2,805,250	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT								11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13)								14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		106,329	106,329		106,329		106,329	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT		166,943	166,943		166,943		166,943	17
18 PROFESSIONAL LIABILITY INSURANCE		168,046	168,046		168,046		168,046	18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		441,318	441,318		441,318		441,318	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,487,187	759,381	3,246,568		3,246,568		3,246,568	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS		34,777	34,777		34,777		34,777	29
30 ADMINISTRATIVE COSTS	555,993	65,383	621,376		621,376		621,376	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	555,993	100,160	656,153		656,153		656,153	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	3,043,180	859,541	3,902,721		3,902,721		3,902,721	32

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2010 TO 04/30/2011

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10
 11/23/2011 13:04

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3429

WORKSHEET M-2

CHECK APPLICABLE BOX [XX] RHC [] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS	5.15	28,740	4,200	21,630	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.42	1,836	2,100	882	3
4	SUBTOTAL (SUM OF LINES 1-3)	5.57	30,576		22,512	4
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	5.57	30,576			8
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9

10	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES				
11	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)			3,246,568	10
12	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)				11
13	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)			3,246,568	12
14	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)			1.000000	13
15	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)			656,153	14
16	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)			1,539,599	15
17	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)			2,195,752	16
18	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)				17
19	SUBTRACT LINE 17 FROM LINE 16			2,195,752	18
20	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)			2,195,752	19
21	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)			5,442,320	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3429

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	5,442,320	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	43,614	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	5,398,706	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	30,576	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	30,576	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	176.57	7

CALCULATION OF LIMIT (1)
 PRIOR TO ON OR AFTER
 JANUARY 1 JANUARY 1 (SEE INSTR.)
 1 2 3

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8	
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	176.57	176.57	176.57	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	7,426	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	1,311,209	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	301	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)	53,148	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)	36,539	14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	1,347,748	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	975,050	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	975,050	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	128,936	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	975,050	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	26,565	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	1,001,615	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	43,884	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	43,884	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	1,045,499	26
27	INTERIM PAYMENTS	941,837	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	103,662	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		30

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
 COMPONENT NO: 14-3429

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

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	2,805,250	2,805,250	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000219	0.001022	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	614	2,867	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	9,486	13,050	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	10,100	15,917	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	3,246,568	3,246,568	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	2,195,752	2,195,752	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.003111	0.004903	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	6,831	10,766	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	16,931	26,683	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	93	435	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	182.05	61.34	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	60	255	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	10,923	15,642	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)		43,614	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)		26,565	16

***** REPORT 97 ***** UTILIZATION STATISTICS *****

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
30 ADULTS & PEDIATRICS	50.21		12.18				62.39 30
31 INTENSIVE CARE UNIT	46.40		12.00				58.40 31
43 NURSERY			76.80				76.80 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	6.41		4.80				11.21 50
52 DELIVERY ROOM & LABOR ROOM			53.45				53.45 52
54 RADIOLOGY-DIAGNOSTIC	4.56		1.75				6.31 54
54.01 RADIOLOGY-ULTRASOUND	8.35		1.68				10.03 54.01
60 LABORATORY	7.24		2.24				9.48 60
62 WHOLE BLOOD & PCKD RED BLOOD CE	53.81						53.81 62
65 RESPIRATORY THERAPY	20.63		5.48				26.11 65
66 PHYSICAL THERAPY	6.60		0.53				7.13 66
69 ELECTROCARDIOLOGY	19.47		1.73				21.20 69
71 MEDICAL SUPPLIES CHRGD TO PATI	30.96		6.10				37.06 71
72 IMPL. DEV. CHARGED TO PATIENT	37.54						37.54 72
73 DRUGS CHARGED TO PATIENTS	18.41		4.90				23.31 73
90 CLINIC	0.46		0.03				0.49 90
91 EMERGENCY	0.04		1.13				1.17 91
92 OBSERVATION BEDS			2.17				2.17 92
200 TOTAL CHARGES	7.45		3.02				10.47 200

***** REPORT 97 ***** UTILIZATION STATISTICS *****

SWING-BED SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	0.06						0.06 54
54.01 RADIOLOGY-ULTRASOUND	0.07						0.07 54.01
60 LABORATORY	0.26						0.26 60
65 RESPIRATORY THERAPY	2.38						2.38 65
66 PHYSICAL THERAPY	3.99						3.99 66
69 ELECTROCARDIOLOGY	0.05						0.05 69
71 MEDICAL SUPPLIES CHRGED TO PATI	1.91						1.91 71
73 DRUGS CHARGED TO PATIENTS	1.60						1.60 73
90 CLINIC	0.01						0.01 90
200 TOTAL CHARGES	0.48						0.48 200

COST CENTER		---	DIRECT COSTS	---	ALLOCATED OVERHEAD	---	TOTAL COSTS	---
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	1,276,010	4.08	-1,276,010	-9.47			1
2	CAP REL COSTS-MVBLE EQUIP	890,352	2.85	-890,352	-6.61			2
3	OTHER CAPITAL RELATED COSTS							3
4	EMPLOYEE BENEFITS	2,857,428	9.14	-2,857,428	-21.20			4
5.01	NONPATIENT TELEPHONES	25,851	0.08	-25,851	-0.19			5.01
5.02	DATA PROCESSING	939,854	3.01	-939,854	-6.97			5.02
5.03	PURCHASING RECEIVING AND STORES	121,134	0.39	-121,134	-0.90			5.03
5.04	ADMITTING	287,990	0.92	-287,990	-2.14			5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	449,577	1.44	-449,577	-3.34			5.05
5.06	OTHER ADMINISTRATIVE AND GENERA	2,226,451	7.12	-2,226,451	-16.52			5.06
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	1,422,975	4.55	-1,422,975	-10.56			7
8	LAUNDRY & LINEN SERVICE	134,467	0.43	-134,467	-1.00			8
9	HOUSEKEEPING	425,252	1.36	-425,252	-3.15			9
10	DIETARY	367,948	1.18	-367,948	-2.73			10
11	CAFETERIA	248,520	0.79	-248,520	-1.84			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	651,265	2.08	-651,265	-4.83			13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	567,126	1.81	-567,126	-4.21			15
16	MEDICAL RECORDS & LIBRARY	547,738	1.75	-547,738	-4.06			16
17	SOCIAL SERVICE	39,497	0.13	-39,497	-0.29			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SRVCES-SALARY & FRINGES APP							21
22	I&R SRVCES-OTHER PRGM COSTS APP							22
23	PARAMED ED PRGM-(SPECIFY)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	1,611,053	5.15	1,974,166	14.65	3,585,219	11.47	30
31	INTENSIVE CARE UNIT	202,512	0.65	260,377	1.93	462,889	1.48	31
43	NURSERY	54,357	0.17	58,227	0.43	112,584	0.36	43
46	OTHER LONG TERM CARE	744,180	2.38	1,041,191	7.72	1,785,371	5.71	46
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,040,419	3.33	1,356,217	10.06	2,396,636	7.67	50
52	DELIVERY ROOM & LABOR ROOM	101,611	0.33	145,515	1.08	247,126	0.79	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	1,382,821	4.42	1,058,517	7.85	2,441,338	7.81	54
54.01	RADIOLOGY-ULTRASOUND	190,900	0.61	129,528	0.96	320,428	1.02	54.01
60	LABORATORY	1,313,060	4.20	910,246	6.75	2,223,306	7.11	60
62	WHOLE BLOOD & PKCD RED BLOOD CE	85,868	0.27	24,843	0.18	110,711	0.35	62
62.30	BLOOD CLOTTING FACTORS ADMIN CO							62.30
65	RESPIRATORY THERAPY	409,039	1.31	303,960	2.25	712,999	2.28	65
66	PHYSICAL THERAPY	674,696	2.16	758,064	5.62	1,432,760	4.58	66
69	ELECTROCARDIOLOGY	15,811	0.05	33,918	0.25	49,729	0.16	69
71	MEDICAL SUPPLIES CHRGD TO PATI	820,235	2.62	299,324	2.22	1,119,559	3.58	71
72	IMPL. DEV. CHARGED TO PATIENT	172,347	0.55	58,735	0.44	231,082	0.74	72
73	DRUGS CHARGED TO PATIENTS	1,093,554	3.50	1,296,639	9.62	2,390,193	7.65	73
76	CARDIAC REHAB	47,570	0.15	78,870	0.59	126,440	0.40	76
76.01	OCCUPATIONAL MEDICINE & WELLNES							76.01
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88	RURAL HEALTH CLINIC (RHC)	3,902,721	12.48	1,539,599	11.42	5,442,320	17.41	88
88.01	RHC II	419,768	1.34	151,602	1.12	571,370	1.83	88.01
88.02	RHC III	309,547	0.99	83,809	0.62	393,356	1.26	88.02
90	CLINIC	1,132,574	3.62	490,897	3.64	1,623,471	5.19	90
91	EMERGENCY	1,085,335	3.47	797,222	5.91	1,882,557	6.02	91
92	OBSERVATION BEDS							92
OTHER REIMBURSABLE COST CENTERS								
OUTPATIENT SERVICE 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
101	HOME HEALTH AGENCY	507,983	1.62	273,872	2.03	781,855	2.50	101
SPECIAL PURPOSE COST CENTERS								
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CAN			29,001	0.22	29,001	0.09	190
192	PHYSICIANS' PRIVATE OFFICES	187,679	0.60	44,020	0.33	231,699	0.74	192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	130,390	0.42	61,739	0.46	192,129	0.61	194.01
194.02	FOUNDATION SERVICES	31,500	0.10	12,180	0.09	43,680	0.14	194.02
194.03	WELLNESS	115,228	0.37	139,341	1.03	254,569	0.81	194.03
194.04	RENTED SPACE			67,816	0.50	67,816	0.22	194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	31,262,193	100.00			31,262,193	100.00	202

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST
EXCLUDING SERVICES NOT SUBJECT TO OPSS.
(WKST D, PART V, COLUMNS 2, 2.01, & 2.02 x
4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1
LESS LINES 61, 66-68, 74, 94, 95 & 96)

2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES 13,606,453
EXCLUDING SERVICES NOT SUBJECT TO OPSS.
(WKST D, PART V, LINE 202, COLUMNS 2, 2.01,
& 2.02 LESS LINES 61, 66-68, 74, 94, 95 &
96)

3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)

MEDIICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES		14-3488 14-3486 14-3429		CLINIC NAME CMH Rural Health Clinic Oblong		REPORTING PERIOD FROM: 5-1-10 TO: 4-30-11		ATTACHMENT #1	
COST CENTER (OMIT CENTS)		COMPENSATION	OTHER	TOTAL COL.1&2	RECLASSI- FICATIONS	RECLASSIFIED TRIAL BALANCE COL.3&4	ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES COL.5&6	
		1	2	3	4	5	6	7	
1 SUPPLEMENTAL COSTS									
2	Pharmacy			-					
3	Patient Transportation			-					
4	Medical Case Management			-					
5	Health Education			-					
6	Nutrition Counseling			-					
7	Others(specify)			-					
8				-					
9				-					
10				-					
11				-					
12	Supplemental Subtotal(sum of lines 2 through 11)		-	-					
13	DENTAL								
14	NON-ALLOWABLE COST CENTERS								
15	HMHK Case Management			-					
16	WIC(Women,Infants, & Children)			-					
17	Fundraising & Public Relations			-					
18	Social Services			-					
19	Unlicensed Social Workers			-					
20	Others(specify)			-					
21				-					
22				-					
23				-					
24				-					
25	Non-Allowable Subtotal(sum of lines 15 - 24)		-	-					
26	Totals for schedule C (sum of lines 12,13, &25)		-	-					

NOTE: This schedule allows for supplemental reimbursement of some costs which are not allowable under the Medicare program.

RURAL HEALTH CENTER DENTAL STATISTICS		CLINIC NAME CMH RHC, Palestine, Oblong		REPORTING PERIOD 14-3486, 14-3429		FROM: 5-1-10 TO: 4-30-11		ATTACHMENT #2	
NONE		COMPENSATION	OTHER	COL.1&2	RECLASSI- FICATIONS	RECLASSIFIED TRIAL BALANCE (COL.3&4)	ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES (COL.5&6)	
		1	2	3	4	5	6	7	
1	RHC DENTAL STAFF COST								
2	Dentists								
3	Dental Hygienist								
4									
5									
6	TOTAL - Dentists(Sum of lines 1 through 5)								
7	Other - Dental Staff								
8									
9									
10									
11	SUBTOTAL- Other Dental Staff(Sum of lines 7-10)								
12	TOTAL - Dental Staff (Sum of lines 6 and 11)								
13	Dental Services Under Agreement								
14									
15	TOTAL DENTAL COST(Sum of lines 12 through 14)								

DENTAL SERVICES PERSONNEL, EQUIVALENTS, HOURS ON SITE, AND ENCOUNTERS

DENTAL SERVICES PERSONNEL		FULL TIME PERSONNEL EQUIVALENTS (FTEs)	HEALTH SERVICES HOURS	ENCOUNTERS		
				ON-SITE	OFF-SITE	TOTAL
16	RHC DENTAL STAFF	1	2	3	4	5
17	Dentists					
18	Dental Hygienist					
19						
20						
21	TOTAL - Dentists(Sum of lines 17 through 20)	0	0	0	0	0
22	Other - Dental Staff					
23						
24						
25						
26	SUBTOTAL-Other Dental Staff(Sum of lines 22 through 25)	0	0	0	0	0
27	TOTAL - Dental Staff(Sum of lines 21 and 26)	0	0	0	0	0
28	Dental Services Under Agreement					
29						
30	TOTAL DENTAL(Sum of lines 27 through 29)	0	0	0	0	0

NOTE: Total dental cost from line 15, column 7, must agree with Attachment #1, line 13.