

CRAWFORD MEMORIAL HOSPITAL

ROBINSON, ILLINOIS

MEDICARE COST ANALYSIS

YEAR ENDED APRIL 30, 2013



Kerber, Eck & Braeckel LLP

CPAs and
Management Consultants

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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, 2013, 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.

Kerber, Eck & Braeckel LLP

Carbondale, Illinois
September 17, 2013

Other Locations

Belleville, IL • Springfield, IL • Jacksonville, IL • Cape Girardeau, MO • St. Louis, MO • Milwaukee, WI

National Government Services, Inc.
Medicare Audit and Reimbursement
P.O. Box 6474
Indianapolis, IN 46206-6474

Dear Sir or Madam:

This cost report of Crawford Memorial Hospital for the fiscal year ended April 30, 2013, includes three Level 20000 Errors.

The 20300 error, which reads the cost to charge ratio on Wkst C, Part I, Col. 11 should not be more than 100% or less than .1%. Line 72 is a result of the department not having enough volume to cover the direct expense plus allocated overhead.

The 20300 error, which reads the cost to charge ratio on Wkst C, Part I, Col. 11 should not be more than 100% or less than .1%. Line 76 is a result of the department not having enough volume to cover the direct expense plus allocated overhead.

The 20300 error, which reads the cost to charge ratio on Wkst C, Part I, Col. 11 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.

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: 09/23/2013 TIME: 08:40
 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: _____
 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 05/01/2012 AND ENDING 04/30/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 09/23/2013 08:40
 .pNFwiJA16200ARwh10db5sioL69v0
 yoyDP0sf77EYCD0Tnt303ro7RwqoN4
 zuC2lycQdH0w1IKr

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

TITLE _____

DATE _____

PI Encryption: 09/23/2013 08:40
 SsLXKv8fxH.p5Nlt3nL2UB90e75ra0
 cvRon007dEziSm62.oyAzdzVQ20LkQ
 T5lEOBlet800IXYe

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5
		PART A 2	PART B 3		
1 HOSPITAL		287,582	124,304		1
2 SUBPROVIDER - IPF					2
3 SUBPROVIDER - IRF					3
4 SUBPROVIDER (OTHER)					4
5 SWING BED - SNF		11,785			5
6 SWING BED - NF					6
7 SKILLED NURSING FACILITY					7
8 NURSING FACILITY					8
9 HOME HEALTH AGENCY					9
10 HEALTH CLINIC - RHC			107,881		10
10.01 HEALTH CLINIC - RHC II			6,038		10.01
10.02 HEALTH CLINIC - RHC III			6,377		10.02
11 HEALTH CLINIC - FQHC					11
12 OUTPATIENT REHABILITATION PROVIDER					12
200 TOTAL		299,367	244,600		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
 2 CITY: ROBINSON STATE: IL

P.O. BOX: 1
 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 6	XVIII 7	XIX 8		
3	HOSPITAL	CRAWFORD MEMORIAL HOSPITAL	14-1343	99914	1	05/01/2005	N	O	P	3
4	SUBPROVIDER - IFF									4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF	CRAWFORD MEMORIAL HOSPITAL	14-2343	99914		05/01/2005	N	O	N	7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF	CRAWFORD MEMORIAL HOSPITAL LTC	14-6150	99914		03/29/2012	N	P	N	9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	CRAWFORD MEMORIAL HHA	14-7175	99914		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	99914		11/11/1996	N	O	N	15
15.01	HOSPITAL-BASED HEALTH CLINIC - RHC II	PALESTINE RURAL HEALTH CLINIC	14-3486	99914		11/21/2006	N	O	N	15.01
15.02	HOSPITAL-BASED HEALTH CLINIC - RHC III	OBLONG RURAL HEALTH CLINIC	14-3488	99914		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: 05/01/2012				TO: 04/30/2013				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		OUT-OF		OUT-OF		MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
		IN-STATE MEDICAID PAID DAYS 1	MEDICAID ELIGIBLE UNPAID DAYS 2	STATE MEDICAID PAID DAYS 3	STATE MEDICAID ELIGIBLE UNPAID DAYS 4					
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.									25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2					26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER IN COLUMN 1, '1' FOR URBAN OR '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				2					27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:				36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.									37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:				38

39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)									1	2
										N	N 39

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V	XVIII	XIX	
		1	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR ADDITIONAL PAYMENT EXCEPTION FOR EXTRAORDINARY CIRCUMSTANCES PURSUANT TO 42 CFR §412.348(f)? IF YES, COMPLETE 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	N	N	48

'N' FOR NO.

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 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60
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
64	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. ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN 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)) 64

ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR
 FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, THE PROGRAM NAME.
 ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF
 UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS
 OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER
 OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL.
 ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)).
 (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

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)) 66
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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.			V XIX 1 2 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 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 106
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME 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- OCCUP- SICAL ATIONAL Y N N N	RESPI- RATORY 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. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 290,795 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR 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.	1 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, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

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

	TITLE XVIII PART A	PART B	TITLE V	TITLE XIX	
155	HOSPITAL	Y	Y	3	N 155
156	SUBPROVIDER - IPF	N	N	4	156
157	SUBPROVIDER - IRF	N	N		157
158	SUBPROVIDER - (OTHER)	N	N		158
159	SNF	N	N		159
160	HHA	N	N		160
161	CMHC		N		161

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
09/23/2013 08:40

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
ENTER 'Y' FOR YES OR 'N' FOR NO.

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. Y 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. 1 168

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	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)	1 N	2	1	
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.	Y/N 1 N	DATE 2	V/I 3 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	
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.	1 Y	2 A	3 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	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N		2 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/N 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				N 15	
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
PS&R REPORT DATA		PART A		PART B	
		Y/N	DATE	Y/N	DATE
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)	1 Y	2 07/09/2013	3 Y	4 07/09/2013
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	N		N	17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

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. N 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 27

INTEREST EXPENSE

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

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. N 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 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 |
|---|-----|------|
| 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT? | 1 | 2 |
| 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | N | 36 |
| 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 | 37 |
| 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS. | | 38 |
| 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS. | | 39 |
| | | 40 |

COST REPORT PREPARER CONTACT INFORMATION

- | | | | |
|-----------------------------|-----------------------------------|----------------|----|
| 41 FIRST NAME: DAVID | LAST NAME: SCHNAKE | TITLE: PARTNER | 41 |
| 42 EMPLOYER: KEB | | | 42 |
| 43 PHONE NUMBER: 6185291040 | E-MAIL ADDRESS: DAVIDS@KEBCPA.COM | | 43 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE	COMPONENT	WKST A LINE NO.	NO OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			TOTAL ALL PATIENTS	
						TITLE V 5	TITLE XVIII 6	TITLE XIX 7		
1			2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	25	9,125	84,600.00		1,944	499	3,525	1
2	HMO									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						248		248	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								30	6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	84,600.00		2,192	499	3,803	7
8	INTENSIVE CARE UNIT	31								8
9	CORONARY CARE UNIT	32								9
10	BURN INTENSIVE CARE UNIT	33								10
11	SURGICAL INTENSIVE CARE UNIT	34								11
12	OTHER SPECIAL CARE (SPECIFY)	35								12
13	NURSERY	43						253	365	13
14	TOTAL (SEE INSTRUCTIONS)		25	9,125	84,600.00		2,192	752	4,168	14
15	CAH VISITS									15
16	SUBPROVIDER - IPF	40								16
17	SUBPROVIDER - IRF	41								17
18	SUBPROVIDER I	42								18
19	SKILLED NURSING FACILITY	44	48	17,520			896		7,615	19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					3,983		4,602	22
23	ASC (DISTINCT PART)	115								23
24	HOSPICE (DISTINCT PART)	116								24
25	CMHC	99								25
26	RHC	88					7,890		30,969	26
26.01	RHC II	88.01					434		4,544	26.01
26.02	RHC III	88.02					267		3,747	26.02
27	TOTAL (SUM OF LINES 14-26)		73							27
28	OBSERVATION BED DAYS							86	429	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (SEE INSTR.)							32	52	32
33	LTCH NON-COVERED DAYS									33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---				----- DISCHARGES -----			TOTAL ALL PATIENTS 15
		TOTAL INTERNS & RESIDENTS 9	EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	TITLE V 12	TITLE XVIII 13	TITLE XIX 14		
1 HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30					504	252	1,179	1
2 HMO									2
3 HMO IPF									3
4 HMO IRF									4
5 HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6 HOSPITAL ADULTS & PEDS. SWING BED NF									6
7 TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8 INTENSIVE CARE UNIT	31								8
9 CORONARY CARE UNIT	32								9
10 BURN INTENSIVE CARE UNIT	33								10
11 SURGICAL INTENSIVE CARE UNIT	34								11
12 OTHER SPECIAL CARE (SPECIFY)	35								12
13 NURSERY	43								13
14 TOTAL (SEE INSTRUCTIONS)			251.55			504	252	1,179	14
15 CAH VISITS									15
16 SUBPROVIDER - IPF	40								16
17 SUBPROVIDER - IRF	41								17
18 SUBPROVIDER I	42								18
19 SKILLED NURSING FACILITY	44		18.72						19
20 NURSING FACILITY	45								20
21 OTHER LONG TERM CARE	46								21
22 HOME HEALTH AGENCY	101		8.56						22
23 ASC (DISTINCT PART)	115								23
24 HOSPICE (DISTINCT PART)	116								24
25 CMHC	99								25
26 RHC	88		36.30						26
26.01 RHC II	88.01		4.09						26.01
26.02 RHC III	88.02		2.59						26.02
27 TOTAL (SUM OF LINES 14-26)			321.81						27
28 OBSERVATION BED DAYS									28
29 AMBULANCE TRIPS									29
30 EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31 EMPLOYEE DISCOUNT DAYS-IRF									31
32 LABOR & DELIVERY DAYS (SEE INSTR.)									32
33 LTCH NON-COVERED DAYS									33

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7175

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY: CLICK HERE TO ENTER

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS		658		30	688	1
2 UNDUPLICATED CENSUS COUNT (SEE INSTRUCTION)		187.00		97.00	284.00	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)			
	STAFF 1	CONTRACT 2	TOTAL 3	
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4 DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			1.01	4
5 OTHER ADMINISTRATIVE PERSONNEL			1.00	5
6 DIRECT NURSING SERVICE			4.24	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE			0.05	8
9 PHYSICAL THERAPY SUPERVISOR			0.27	9
10 OCCUPATIONAL THERAPY SERVICE			0.13	10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE			0.02	12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE				14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE			1.84	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) 5	
	WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21 SKILLED NURSING VISITS	2,017	135	45	49	2,246	21
22 SKILLED NURSING VISIT CHARGES	356,536	24,030	8,010	8,572	397,148	22
23 PHYSICAL THERAPY VISITS	807	4	3	1	815	23
24 PHYSICAL THERAPY VISIT CHARGES	145,659	728	546	182	147,115	24
25 OCCUPATIONAL THERAPY VISITS	198		4		202	25
26 OCCUPATIONAL THERAPY VISIT CHARGES	35,826		728		36,554	26
27 SPEECH PATHOLOGY VISITS	62				62	27
28 SPEECH PATHOLOGY VISIT CHARGES	11,284				11,284	28
29 MEDICAL SOCIAL SERVICE VISITS						29
30 MEDICAL SOCIAL SERVICE VISIT CHARGES						30
31 HOME HEALTH AIDE VISITS	623	17	2	16	658	31
32 HOME HEALTH AIDE VISIT CHARGES	51,919	1,428	168	1,302	54,817	32
33 TOTAL VISITS (SUM OF LINES 21, 23, 25, 27, 29, AND 31)	3,707	156	54	66	3,983	33
34 OTHER CHARGES						34
35 TOTAL CHARGES (SUM OF LINES 22, 24, 26, 28, 30, 32 AND 34)	601,224	26,186	9,452	10,056	646,918	35
36 TOTAL NUMBER OF EPISODES (STANDARD/ NON-OUTLIER)	204		21	3	228	36
37 TOTAL NUMBER OF OUTLIER EPISODES		3			3	37
38 TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	32,840	1,855	540	1,582	36,817	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	14		14
10	RML			10
11	RLX			11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB			16
17	RVA	16		16
18	RHC	30		30
19	RHB	14		14
20	RHA	50		50
21	RMC	83		83
22	RMB	55		55
23	RMA	333		333
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1	48		48
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1	20		20
35	HB2			35
36	HB1			36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1	61		61
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2	8		8
48	CD1			48
49	CC2			49
50	CC1			50
51	CB2			51
52	CB1	7		7
53	CA2			53
54	CA1	47		47
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	30		30
67	BA2			67
68	BA1	4		4

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 08:40

PROSPECTIVE PAYMENT FOR SNF
 STATISTICAL DATA

WORKSHEET S-7

		GROUP	SNF	SWING BED	TOTAL
		1	DAYS	SNF DAYS	(COLS.
			2	3	2 + 3)
					4
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1		6		6 72
73	PC2				73
74	PC1				74
75	PE2				75
76	PB1		27		27 76
77	PA2				77
78	PA1		43		43 78
199	AAA				199
200	TOTAL		896		896 200

		CBSA AT	CBSA ON/AFTER	
		BEGINNING	OCT 1 OF THE	
		OF COST	COST REPORTING	
		REPORTING	PERIOD (IF	
		PERIOD	APPLICABLE)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).	00014	00014	201

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

		EXPENSES	PERCENTAGE	ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES?
		1	2	3
202	STAFFING	794,945	66.98%	202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING	2,348	0.20%	205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)	1,186,811		207

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 08:40

RHC I
 COMPONENT NO: 14-3429

WORKSHEET S-8

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

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
 1

DATE
 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? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. 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		

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

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1
 N 2 12
 13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?
 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 IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE
 NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V,
 XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS) Y/N V XVIII XIX TOTAL 15

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 08:40

RHC II
 COMPONENT NO: 14-3486

WORKSHEET S-8

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

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
 1

DATE
 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? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. 1 2 10
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N

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		

(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 12
 13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 13
 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.

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 IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)

Y/N	V	XVIII	XIX	TOTAL
N				15

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 08:40

RHC III
 COMPONENT NO: 14-3488

WORKSHEET S-8

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

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? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.
 IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. 1 2 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 12
 N N
 13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 13

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.

14 PROVIDER NAME: CCN NUMBER: 14

	Y/N	V	XVIII	XIX	TOTAL	
15	N					15

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

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 202, COL. 3 DIVIDED BY LINE 202, COL. 8) 0.449568 1

MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)

2 NET REVENUE FROM MEDICAID 2,010,616 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 2,361,932 5
 6 MEDICAID CHARGES 11,117,115 6
 7 MEDICAID COST (LINE 1 TIMES LINE 6) 4,997,899 7
 8 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) 625,351 8
 IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)

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

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)

13 NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9) 13
 14 CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10) 14
 15 STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14) 15
 16 DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13) 16
 IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.

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) 625,351 19

	UNINSURED PATIENTS	INSURED PATIENTS	TOTAL
	1	2	3
20 TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	2,596,343	424,323	3,020,666 20
21 COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	1,167,233	190,762	1,357,995 21
22 PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	173,872	28,417	202,289 22
23 COST OF CHARITY CARE	993,361	162,345	1,155,706 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)			2,251,638 26
27 MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			599,303 27
28 NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			1,652,335 28
29 COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			742,837 29
30 COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			1,898,543 30
31 TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			2,523,894 31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,873,813	1,873,813	76,720	1
2	00200		918,385	918,385	3,877	2
3	00300		17,179	17,179	-17,179	3
4	00400	168,418	3,039,842	3,208,260	5,379	4
5.01	00540		1,466	1,466	29,807	5.01
5.02	00550	183,597	643,317	826,914		5.02
5.03	00560	140,913	37,993	178,906		5.03
5.04	00570	302,848	45,993	348,841	-30,240	5.04
5.05	00580	269,714	337,289	607,003		5.05
5.06	00590	499,001	1,882,434	2,381,435		5.06
7	00700	404,537	1,044,748	1,449,285	29,642	7
8	00800	89,595	48,922	138,517		8
9	00900	300,887	140,465	441,352		9
10	01000	433,665	375,498	809,163	-432,408	10
11	01100				432,408	11
13	01300	610,617	95,979	706,596		13
14	01400					14
15	01500	547,365	476,666	1,024,031		15
16	01600	565,542	204,362	769,904	7,934	16
17	01700	28,648	2,460	31,108		17
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,769,894	309,952	2,079,846	-173,802	30
43	04300				60,744	43
44	04400	682,696	201,256	883,952	166,036	44
ANCILLARY SERVICE COST CENTERS						
50	05000	794,945	362,732	1,157,677	726,855	50
52	05200		138	138	113,058	52
53	05300	629,055	97,800	726,855	-726,855	53
54	05400	641,857	748,720	1,390,577	-13,428	54
54.01	05401		200,112	200,112		54.01
60	06000	556,223	972,887	1,529,110	-93,696	60
62	06200				93,696	62
65	06500	345,074	161,673	506,747		65
66	06600	601,313	340,349	941,662	-22,986	66
69	06900	21,929	2,098	24,027		69
71	07100		906,647	906,647	12,936	71
72	07200		455,660	455,660		72
73	07300		1,130,724	1,130,724	13,428	73
76	03950	62,600	11,107	73,707		76
OUTPATIENT SERVICE COST CENTERS						
88	08800	3,473,899	433,633	3,907,532	180,192	88
88.01	08801	269,008	137,876	406,884	5,372	88.01
88.02	08802	289,840	75,256	365,096	25,627	88.02
90	09000	2,120,962	1,435,518	3,556,480	12,415	90
91	09100	667,278	1,871,214	2,538,492		91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
101	10100	442,665	153,888	596,553	-9,184	101
SPECIAL PURPOSE COST CENTERS						
113	11300		467,892	467,892	-467,892	113
118		17,914,585	21,663,943	39,578,528	8,456	118
NONREIMBURSABLE COST CENTERS						
190	19000					190
192	19200	79,702	153,870	233,572	20,045	192
194	07950					194
194.01	07951		112,784	112,784	-25,152	194.01
194.02	07952	25,615	28,476	54,091		194.02
194.03	07953	98,765	15,812	114,577	-3,349	194.03
194.04	07954					194.04
200		18,118,667	21,974,885	40,093,552		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	1,950,533	-77,153	1,873,380	1
2	00200	922,262	-271,661	650,601	2
3	00300				3
4	00400	3,213,639	-231,358	2,982,281	4
5.01	00540	31,273		31,273	5.01
5.02	00550	826,914		826,914	5.02
5.03	00560	178,906		178,906	5.03
5.04	00570	318,601		318,601	5.04
5.05	00580	607,003		607,003	5.05
5.06	00590	2,381,435	-198,115	2,183,320	5.06
7	00700	1,478,927	-2,811	1,476,116	7
8	00800	138,517		138,517	8
9	00900	441,352		441,352	9
10	01000	376,755		376,755	10
11	01100	432,408	-164,186	268,222	11
13	01300	706,596		706,596	13
14	01400				14
15	01500	1,024,031	-267,269	756,762	15
16	01600	777,838	-1,737	776,101	16
17	01700	31,108		31,108	17
INPATIENT ROUTINE SERV COST CENTERS					
30	03000	1,906,044	-18,000	1,888,044	30
43	04300	60,744		60,744	43
44	04400	1,049,988		1,049,988	44
ANCILLARY SERVICE COST CENTERS					
50	05000	1,884,532	-592,665	1,291,867	50
52	05200	113,196		113,196	52
53	05300				53
54	05400	1,377,149		1,377,149	54
54.01	05401	200,112		200,112	54.01
60	06000	1,435,414		1,435,414	60
62	06200	93,696		93,696	62
65	06500	506,747	-32,640	474,107	65
66	06600	918,676		918,676	66
69	06900	24,027		24,027	69
71	07100	919,583		919,583	71
72	07200	455,660		455,660	72
73	07300	1,144,152		1,144,152	73
76	03950	73,707		73,707	76
OUTPATIENT SERVICE COST CENTERS					
88	08800	4,087,724	-444,995	3,642,729	88
88.01	08801	412,256	-10	412,246	88.01
88.02	08802	390,723	-12,073	378,650	88.02
90	09000	3,568,895	-2,151,770	1,417,125	90
91	09100	2,538,492	-1,322,678	1,215,814	91
92	09200				92
OTHER REIMBURSABLE COST CENTERS					
101	10100	587,369	-40,252	547,117	101
SPECIAL PURPOSE COST CENTERS					
113	11300				113
118		39,586,984	-5,829,373	33,757,611	118
NONREIMBURSABLE COST CENTERS					
190	19000				190
192	19200	253,617		253,617	192
194	07950				194
194.01	07951	87,632		87,632	194.01
194.02	07952	54,091		54,091	194.02
194.03	07953	111,228		111,228	194.03
194.04	07954				194.04
200		40,093,552	-5,829,373	34,264,179	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		SALARY	OTHER
			LINE #			
	1	2	3		4	5
1 R/C HHA MED SUPPLIES	A	MEDICAL SUPPLIES CHRGD TO PA	71			12,936 1
500 TOTAL RECLASSIFICATIONS						12,936 500
CODE LETTER - A						
1 LTC ADMITTING COSTS	D	SKILLED NURSING FACILITY	44		376	57 1
500 TOTAL RECLASSIFICATIONS					376	57 500
CODE LETTER - D						
1 R/C CAFETERIA COSTS	F	CAFETERIA	11		231,746	200,662 1
500 TOTAL RECLASSIFICATIONS					231,746	200,662 500
CODE LETTER - F						
1 R/C COST OF BLOOD	G	WHOLE BLOOD & PACKED RED BLOO	62			93,696 1
500 TOTAL RECLASSIFICATIONS						93,696 500
CODE LETTER - G						
1 PBX COST	H	NONPATIENT TELEPHONES	5.01		25,877	3,930 1
500 TOTAL RECLASSIFICATIONS					25,877	3,930 500
CODE LETTER - H						
1 R/C DEPR OBLONG CLINIC	I					1
500 TOTAL RECLASSIFICATIONS						500
CODE LETTER - I						
1 R/C DEPR PROF BLDGS	J	PROFESSIONAL BUILDINGS	194.01			21,160 1
2		RURAL HEALTH CLINIC (RHC)	88			183,713 2
3		RHC II	88.01			5,372 3
4		CLINIC	90			22,844 4
5		HOME HEALTH AGENCY	101			3,752 5
6		WELLNESS	194.03			2,030 6
500 TOTAL RECLASSIFICATIONS						238,871 500
CODE LETTER - J						
1 R/C SNF DEPR	K	SKILLED NURSING FACILITY	44			165,603 1
500 TOTAL RECLASSIFICATIONS						165,603 500
CODE LETTER - K						
1 R/C LABOR/DEL & NB COSTS	L	NURSERY	43		49,935	10,809 1
2		DELIVERY ROOM & LABOR ROOM	52		93,053	20,005 2
500 TOTAL RECLASSIFICATIONS					142,988	30,814 500
CODE LETTER - L						
1 R/C TRANSCRIPTION TXFR	N	MEDICAL RECORDS & LIBRARY	16			7,934 1
2						2
500 TOTAL RECLASSIFICATIONS						7,934 500
CODE LETTER - N						
1 RADIOLOGY CONTRAST ISOVIEW DRUGS	O	DRUGS CHARGED TO PATIENTS	73			13,428 1
500 TOTAL RECLASSIFICATIONS						13,428 500
CODE LETTER - O						
1 R/C OR COST	Q	OPERATING ROOM	50		629,055	97,800 1
500 TOTAL RECLASSIFICATIONS					629,055	97,800 500
CODE LETTER - Q						
1 R/C PALESTINE/OBLONG DRS	R	PHYSICIANS' PRIVATE OFFICES	192			20,045 2
2		RHC III	88.02			25,627 3
3						45,672 500
500 TOTAL RECLASSIFICATIONS						45,672 500
CODE LETTER - R						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE		
			LINE #	SALARY	
	1	2	3	4	5
1 HEALTHWORKS COST	U	EMPLOYEE BENEFITS	4	4,637	742 1
500 TOTAL RECLASSIFICATIONS				4,637	742 500
CODE LETTER - U					
1 UTILITIES	V	OPERATION OF PLANT	7		29,642 1
2					2
3					3
500 TOTAL RECLASSIFICATIONS					29,642 500
CODE LETTER - V					
1 INTEREST EXPENSE	W	CAP REL COSTS-BLDG & FIXT	1		467,892 1
500 TOTAL RECLASSIFICATIONS					467,892 500
CODE LETTER - W					
1 RHC UTILITIES	X	RURAL HEALTH CLINIC (RHC)	88		46,312 1
500 TOTAL RECLASSIFICATIONS					46,312 500
CODE LETTER - X					
GRAND TOTAL (INCREASES)				1,034,679	1,455,991

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		12,936	1
500 TOTAL RECLASSIFICATIONS					12,936	500
CODE LETTER - A						
1 LTC ADMITTING COSTS	D	ADMITTING	5.04	376	57	1
500 TOTAL RECLASSIFICATIONS				376	57	500
CODE LETTER - D						
1 R/C CAFETERIA COSTS	F	DIETARY	10	231,746	200,662	1
500 TOTAL RECLASSIFICATIONS				231,746	200,662	500
CODE LETTER - F						
1 R/C COST OF BLOOD	G	LABORATORY	60		93,696	1
500 TOTAL RECLASSIFICATIONS					93,696	500
CODE LETTER - G						
1 PBX COST	H	ADMITTING	5.04	25,877	3,930	1
500 TOTAL RECLASSIFICATIONS				25,877	3,930	500
CODE LETTER - H						
1 R/C DEPR OBLONG CLINIC	I					9 1
500 TOTAL RECLASSIFICATIONS						500
CODE LETTER - I						
1 R/C DEPR PROF BLDGS	J	CAP REL COSTS-BLDG & FIXT	1		238,871	9 1
2						9 2
3						9 3
4						9 4
5						9 5
6						6
500 TOTAL RECLASSIFICATIONS					238,871	500
CODE LETTER - J						
1 R/C SNF DEPR	K	CAP REL COSTS-BLDG & FIXT	1		165,603	9 1
500 TOTAL RECLASSIFICATIONS					165,603	500
CODE LETTER - K						
1 R/C LABOR/DEL & NB COSTS	L	ADULTS & PEDIATRICS	30	142,988	30,814	1
2						2
500 TOTAL RECLASSIFICATIONS				142,988	30,814	500
CODE LETTER - L						
1 R/C TRANSCRIPTION TXFR	N	RURAL HEALTH CLINIC (RHC)	88		4,161	1
2		CLINIC	90		3,773	2
500 TOTAL RECLASSIFICATIONS					7,934	500
CODE LETTER - N						
1 RADIOLOGY CONTRAST ISOVIEW DRUGS	O	RADIOLOGY-DIAGNOSTIC	54		13,428	1
500 TOTAL RECLASSIFICATIONS					13,428	500
CODE LETTER - O						
1 R/C OR COST	Q	ANESTHESIOLOGY	53	629,055	97,800	1
500 TOTAL RECLASSIFICATIONS				629,055	97,800	500
CODE LETTER - Q						
1 R/C PALESTINE/OBLONG DRS	R	RURAL HEALTH CLINIC (RHC)	88		45,672	1
2						2
3						3
500 TOTAL RECLASSIFICATIONS					45,672	500
CODE LETTER - R						

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE 1	COST CENTER 6	DECREASE			WKST A-7 REF. 10
			LINE # 7	SALARY 8	OTHER 9	
1 HEALTHWORKS COST	U	WELLNESS	194.03	4,637	742	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - U				4,637	742	500
1 UTILITIES	V					1
2		PHYSICAL THERAPY	66		22,986	2
3		CLINIC	90		6,656	3
500 TOTAL RECLASSIFICATIONS CODE LETTER - V					29,642	500
1 INTEREST EXPENSE	W	INTEREST EXPENSE	113		467,892	11 1
500 TOTAL RECLASSIFICATIONS CODE LETTER - W					467,892	500
1 RHC UTILITIES	X	PROFESSIONAL BUILDINGS	194.01		46,312	1
500 TOTAL RECLASSIFICATIONS CODE LETTER - X					46,312	500
GRAND TOTAL (DECREASES)				1,034,679	1,455,991	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
		PURCHASE 2	DONATION 3	TOTAL 4			
1 LAND	48,365					48,365	1
2 LAND IMPROVEMENTS	1,485,155					1,485,155	2
3 BUILDINGS AND FIXTURES	33,445,419	8,123,499		8,123,499	2,536,924	39,031,994	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	11,253,684	567,852		567,852	11,079	11,810,457	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	46,232,623	8,691,351		8,691,351	2,548,003	52,375,971	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	46,232,623	8,691,351		8,691,351	2,548,003	52,375,971	10

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

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,873,813						1,873,813 1
2 CAP REL COSTS-MVBLE EQUIP	918,385						918,385 2
3 TOTAL (SUM OF LINES 1-2)	2,792,198						2,792,198 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

COMPUTATION

OF RATIOS

ALLOCATION OF OTHER CAPITAL

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3		RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL (SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT	40,517,149		40,517,149	0.774298			13,302	13,302 1	
2 CAP REL COSTS-MVBLE EQUIP	11,810,457		11,810,457	0.225702			3,877	3,877 2	
3 TOTAL (SUM OF LINES 1-2)	52,327,606		52,327,606	1.000000			17,179	17,179 3	

SUMMARY OF CAPITAL

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,469,339	-77,153	467,892			13,302	1,873,380 1
2 CAP REL COSTS-MVBLE EQUIP	646,724					3,877	650,601 2
3 TOTAL	2,116,063	-77,153	467,892			17,179	2,523,981 3

ADJUSTMENTS TO EXPENSES

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
			COST CENTER	LINE NO.	WKST A-7	REF
	1	2	3	4	5	
1 INVESTMENT INCOME-BUILDINGS & FIXTURES (CHAPTER 2)	A	-77,153	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	-1,353,078				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	-164,186	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	-1,737	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		RESPIRATORY THERAPY	65		23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66		24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)			UTILIZATION REVIEW-SNF	114		25
26 DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27 DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2		27
28 NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19		28
29 PHYSICIANS' ASSISTANT						29
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32 CAH HIT ADJ FOR DEPRECIATION AND	A	-271,661	CAP REL COSTS-MVBLE EQUIP	2	9	32
33 PHYS RECRUITING	A	-21,302	OTHER ADMINISTRATIVE AND GENERA	5.06		33
33.11 EMPLOYEE INJURY	A	-10,536	EMPLOYEE BENEFITS	4		33.11
33.22 EMPLOYEE PHYSICALS	A	-957	EMPLOYEE BENEFITS	4		33.22
34 ADVERTISING	A	-104,328	OTHER ADMINISTRATIVE AND GENERA	5.06		34
35 TV ADMINISTRATION	A	-6,255	OTHER ADMINISTRATIVE AND GENERA	5.06		35
36 TV UTILITIES & REPAIR	A	-2,811	OPERATION OF PLANT	7		36
37						37
38 EMPLOYEE DISCOUNTS	A	-49,921	EMPLOYEE BENEFITS	4		38
39 OTHER A & G	A	-54,758	OTHER ADMINISTRATIVE AND GENERA	5.06		39
40 EMPLOYEE SALES - PHARMACY	B	-24,668	PHARMACY	15		40
41						41
42 CONSULTING CLINIC	B	-70,859	CLINIC	90		42
42.11 OTHER INCOME ROBINSON RHC	B	-190,336	RURAL HEALTH CLINIC (RHC)	88		42.11
43 340B REVENUE	B	-242,601	PHARMACY	15		43
44 PHYSICIAN EXPENSES	A	-1,389,456	CLINIC	90		44
45 PHYSICIAN EXPENSES	A	-126,432	EMPLOYEE BENEFITS	4		45
46 PHYSICIAN EXPENSES	A	-254,030	RURAL HEALTH CLINIC (RHC)	88		46
47 PHYSICIAN EXPENSES	A	-10	RHC II	88.01		47
48 PHYSICIAN EXPENSES	A	-12,073	RHC III	88.02		48
49 NON ALLOWABLE ADS	A	-629	RURAL HEALTH CLINIC (RHC)	88		49
49.01 NONALLOW CARELINK COST	A	-40,252	HOME HEALTH AGENCY	101		49.01
49.02 MISC INCOME	B	-45,944	OTHER ADMINISTRATIVE AND GENERA	5.06		49.02
49.03 AHA & IHA DUES	A	-13,613	OTHER ADMINISTRATIVE AND GENERA	5.06		49.03
49.04 OB LOCUM TENUMS	A	-18,000	ADULTS & PEDIATRICS	30		49.04
49.05 NONPATIENT CPR	B	-1,978	OTHER ADMINISTRATIVE AND GENERA	5.06		49.05
49.07 DONATIONS, PROJECTS	B	-54,102	OTHER ADMINISTRATIVE AND GENERA	5.06		49.07
49.08 DME - A&P	A	-2,240	EMERGENCY	91		49.08
49.10 DME -ER	A	-386	CLINIC	90		49.10
49.12 CRNA FEES	A	-38,400	OPERATING ROOM	50		49.12

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
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ADJUSTMENTS TO EXPENSES

DESCRIPTION	BASIS 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
			COST CENTER 3	LINE NO. 4	WKST A-7 REF 5	
49.13 ADMIN CLAIMS FEES	A	120,467	OTHER ADMINISTRATIVE AND GENERA	5.06	49.13	
49.15 PHYSICIAN FEES	A	-691,069	CLINIC	90	49.15	
49.16 CRNA	A	-554,265	OPERATING ROOM	50	49.16	
49.17 CRNA	A	-43,512	EMPLOYEE BENEFITS	4	49.17	
49.18 NONALLOW ADS	A	-16,302	OTHER ADMINISTRATIVE AND GENERA	5.06	49.18	
50 TOTAL (SUM OF LINES 1 THRU 49)		-5,829,373			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-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		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	32,640	32,640					1
2	91	EMERGENCY	AGGREGATE	1,717,308	1,320,438	396,870				2
200		TOTAL		1,749,948	1,353,078	396,870				200

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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	LINE NO.	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION 12	PROVIDER COMPONENT SHARE OF COLUMN 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COLUMN 14 15	ADJUSTED RCE LIMIT 16	RCE DIS- ALLOWANCE 17	ADJUST- MENT 18	
1	65	RESPIRATORY THERAPY	AGGREGATE							32,640	1
2	91	EMERGENCY	AGGREGATE							1,320,438	2
200		TOTAL								1,353,078	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3
 PARTS I & II

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					260	3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS					867	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.50	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		3,514.00				9
10	AHSEA		73.97				10
11	STANDARD TRAVEL ALLOWANCE	36.99	36.99				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					259,931	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					259,931	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					259,931	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					259,931	23

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
09/23/2013 08:40

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3
PARTS III & IV

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

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

STANDARD TRAVEL ALLOWANCE			
24	THERAPISTS	9,617	24
25	ASSISTANTS		25
26	SUBTOTAL	9,617	26
27	STANDARD TRAVEL EXPENSE	1,430	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	11,047	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
29	THERAPISTS		29
30	ASSISTANTS		30
31	SUBTOTAL		31
32	OPTIONAL TRAVEL EXPENSE		32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	11,047	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		35

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

STANDARD TRAVEL EXPENSE			
36	THERAPISTS	32,070	36
37	ASSISTANTS		37
38	SUBTOTAL	32,070	38
39	STANDARD TRAVEL EXPENSE	4,769	39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE			
40	THERAPISTS		40
41	ASSISTANTS		41
42	SUBTOTAL		42
43	OPTIONAL TRAVEL EXPENSE		43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES			
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	36,839	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE		45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE		46

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 08:40

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3
 PARTS V, VI & VII

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD	93.00			93.00	47
48	OVERTIME RATE	110.96				48
49	TOTAL OVERTIME	10,319				49
CALCULATION OF LIMIT						
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY	100.00			100.00	50
51	ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50	2,080.00			2,080.00	51
DETERMINATION OF OVERTIME ALLOWANCE						
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT	73.97				52
53	OVERTIME COST LIMITATION	153,858				53
54	MAXIMUM OVERTIME COST	10,319				54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA	6,879				55
56	OVERTIME ALLOWANCE	3,440			3,440	56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT				259,931	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE				11,047	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES				36,839	59
60	OVERTIME ALLOWANCE				3,440	60
61	EQUIPMENT COST					61
62	SUPPLIES					62
63	TOTAL ALLOWANCE				311,257	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES				229,358	64
65	EXCESS OVER LIMITATION					65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDG & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,873,380	1,873,380				1
2 CAP REL COSTS-MVBLE EQUIP	650,601		650,601			2
4 EMPLOYEE BENEFITS	2,982,281	17,078	4,230	3,003,589		4
5.01 NONPATIENT TELEPHONES	31,273		153	4,939	36,365	5.01
5.02 DATA PROCESSING	826,914	16,388	87,094	35,044	299	5.02
5.03 PURCHASING RECEIVING AND STORES	178,906	43,602	1,799	26,897	598	5.03
5.04 ADMITTING	318,601	14,416	1,964	52,795	797	5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	607,003	23,842	2,348	51,482	996	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	2,183,320	189,318	10,813	95,247	1,494	5.06
7 OPERATION OF PLANT	1,476,116	122,761	15,305	77,216	598	7
8 LAUNDRY & LINEN SERVICE	138,517	50,071	2,018	17,102	100	8
9 HOUSEKEEPING	441,352	14,435	918	57,432	100	9
10 DIETARY	376,755	66,064	17,768	38,541	797	10
11 CAFETERIA	268,222	38,771		44,235		11
13 NURSING ADMINISTRATION	706,596	9,012		116,552	598	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	756,762	25,006	70,327	104,479	897	15
16 MEDICAL RECORDS & LIBRARY	776,101	61,292	14,957	107,948	1,295	16
17 SOCIAL SERVICE	31,108	986	195	5,468	199	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,888,044	226,256	82,492	310,537	4,384	30
43 NURSERY	60,744	8,223		9,531	100	43
44 SKILLED NURSING FACILITY	1,049,988		6,831	130,382	2,590	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,291,867	209,334	128,341	166,012	1,793	50
52 DELIVERY ROOM & LABOR ROOM	113,196	24,670		17,762		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,377,149	66,991	55,995	122,515	1,494	54
54.01 RADIOLOGY-ULTRASOUND	200,112	9,565	247			54.01
60 LABORATORY	1,435,414	44,174	14,060	106,170	697	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	93,696	2,169				62
65 RESPIRATORY THERAPY	474,107	22,679	14,074	65,866	498	65
66 PHYSICAL THERAPY	918,676	197,660	9,507	114,776	697	66
69 ELECTROCARDIOLOGY	24,027	5,364	797	4,186	199	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	919,583	13,686				71
72 IMPL. DEV. CHARGED TO PATIENT	455,660	6,902				72
73 DRUGS CHARGED TO PATIENTS	1,144,152					73
76 CARDIAC REHAB	73,707	60,187	2,199	11,949	199	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	3,642,729		35,597	614,605	6,576	88
88.01 RHC II	412,246		203	51,345	697	88.01
88.02 RHC III	378,650		3,037	53,019	598	88.02
90 CLINIC	1,417,125		30,233	139,627	4,384	90
91 EMERGENCY	1,215,814	189,318	26,113	127,367	1,096	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	547,117		5,499	84,494	897	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	33,757,611	1,780,220	645,114	2,965,520	35,667	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		13,804				190
192 PHYSICIANS' PRIVATE OFFICES	253,617			15,213		192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	87,632				498	194.01
194.02 FOUNDATION SERVICES	54,091	986		4,889	100	194.02
194.03 WELLNESS	111,228		5,487	17,967	100	194.03
194.04 RENTED SPACE		78,370				194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	34,264,179	1,873,380	650,601	3,003,589	36,365	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	DATA PROCES- SSING 5.02	PURCHASING RECEIVING AND STORE 5.03	ADMITTING 5.04	CASHIERING /ACCOUNTS RECEIVABLE 5.05	SUBTOTAL (COLS. 0-4) 4A	
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	965,739					5.02
5.03 PURCHASING RECEIVING AND STORES		251,802				5.03
5.04 ADMITTING		1,338	389,911			5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	608,705	268		1,294,644		5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	357,034	3,479			2,840,705	5.06
7 OPERATION OF PLANT		4,549			1,696,545	7
8 LAUNDRY & LINEN SERVICE		1,873			209,681	8
9 HOUSEKEEPING		3,211			517,448	9
10 DIETARY		1,606			501,531	10
11 CAFETERIA					351,228	11
13 NURSING ADMINISTRATION		268			833,026	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		2,141			959,612	15
16 MEDICAL RECORDS & LIBRARY		1,338			962,931	16
17 SOCIAL SERVICE					37,956	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		7,225	90,924	70,934	2,680,796	30
43 NURSERY			9,061	6,144	93,803	43
44 SKILLED NURSING FACILITY		5,084			1,194,875	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		14,450	68,267	222,221	2,102,285	50
52 DELIVERY ROOM & LABOR ROOM			21,844	14,810	192,282	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		9,633	32,554	270,912	1,937,243	54
54.01 RADIOLOGY-ULTRASOUND			9,289	48,689	267,902	54.01
60 LABORATORY		35,322	47,528	266,177	1,949,542	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			3,925	5,113	104,903	62
65 RESPIRATORY THERAPY		2,943	16,712	32,613	629,492	65
66 PHYSICAL THERAPY		2,141	6,458	56,584	1,306,499	66
69 ELECTROCARDIOLOGY		268	3,443	11,359	49,643	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		83,484	29,144	36,537	1,082,434	71
72 IMPL. DEV. CHARGED TO PATIENT		42,012	6,590	8,230	519,394	72
73 DRUGS CHARGED TO PATIENTS			38,296	113,634	1,296,082	73
76 CARDIAC REHAB		268	9	3,254	151,772	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		11,239			4,310,746	88
88.01 RHC II		1,873			466,364	88.01
88.02 RHC III		1,338			436,642	88.02
90 CLINIC		7,760	63	31,263	1,630,455	90
91 EMERGENCY		4,014	5,804	79,854	1,649,380	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY		2,141		16,316	656,464	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	965,739	251,266	389,911	1,294,644	33,619,661	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					13,804	190
192 PHYSICIANS' PRIVATE OFFICES					268,830	192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS					88,130	194.01
194.02 FOUNDATION SERVICES		268			60,334	194.02
194.03 WELLNESS		268			135,050	194.03
194.04 RENTED SPACE					78,370	194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	965,739	251,802	389,911	1,294,644	34,264,179	202

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	
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	2,840,705					5.06
7 OPERATION OF PLANT	153,369	1,849,914				7
8 LAUNDRY & LINEN SERVICE	18,955	50,321	278,957			8
9 HOUSEKEEPING	46,778	14,508		578,734		9
10 DIETARY	45,339	66,395	5,230	18,280	636,775	10
11 CAFETERIA	31,751	38,965		10,728		11
13 NURSING ADMINISTRATION	75,306	9,057		2,494		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	86,750	25,131		6,919		15
16 MEDICAL RECORDS & LIBRARY	87,050	61,598		16,959		16
17 SOCIAL SERVICE	3,431	991		273		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	242,347	227,386	103,417	62,604	218,727	30
43 NURSERY	8,480	8,265	2,526	2,275		43
44 SKILLED NURSING FACILITY	108,018	215,753	84,727	59,401	355,709	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	190,049	210,382	34,609	57,922	6,013	50
52 DELIVERY ROOM & LABOR ROOM	17,382	24,794	3,292	6,826		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	175,129	67,326	13,950	18,536		54
54.01 RADIOLOGY-ULTRASOUND	24,219	9,612		2,646		54.01
60 LABORATORY	176,241	44,395	172	12,223		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	9,483	2,180		600		62
65 RESPIRATORY THERAPY	56,907	22,792	1,917	6,275		65
66 PHYSICAL THERAPY	118,109	198,649	6,237	54,692		66
69 ELECTROCARDIOLOGY	4,488	5,391		1,484		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	97,853	13,755		3,787		71
72 IMPL. DEV. CHARGED TO PATIENT	46,954	6,937		1,910		72
73 DRUGS CHARGED TO PATIENTS	117,167					73
76 CARDIAC REHAB	13,720	60,489		16,654		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	389,685		2,607	73,919		88
88.01 RHC II	42,160		262			88.01
88.02 RHC III	39,473		106			88.02
90 CLINIC	147,395	190,543	4,276	52,460		90
91 EMERGENCY	149,106	190,265	12,818	52,384	56,326	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	59,345			2,455		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	2,782,439	1,765,880	276,146	544,706	636,775	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,248	13,874		3,820		190
192 PHYSICIANS' PRIVATE OFFICES	24,303					192
NONREIMBURSEABLE						
194 PROFESSIONAL BUILDINGS	7,967			10,891		194.01
194.02 FOUNDATION SERVICES	5,454	991		273		194.02
194.03 WELLNESS	12,209	69,169	2,811	19,044		194.03
194.04 RENTED SPACE	7,085					194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	2,840,705	1,849,914	278,957	578,734	636,775	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	11	13	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
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	432,672					11
13 NURSING ADMINISTRATION	16,641	936,524				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	12,943	57,012	1,148,367			15
16 MEDICAL RECORDS & LIBRARY	29,584			1,158,122		16
17 SOCIAL SERVICE	1,849	6,532			51,032	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	61,018	287,936		65,874	25,516	30
43 NURSERY	1,849	11,816		5,705		43
44 SKILLED NURSING FACILITY	35,131	161,454			25,516	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	31,433	142,733		206,370		50
52 DELIVERY ROOM & LABOR ROOM	5,547	22,024		13,754		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	22,188			251,599		54
54.01 RADIOLOGY-ULTRASOUND				45,216		54.01
60 LABORATORY	20,339			247,191		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				4,748		62
65 RESPIRATORY THERAPY	12,943	59,146		30,287		65
66 PHYSICAL THERAPY	20,339			52,547		66
69 ELECTROCARDIOLOGY				10,548		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				33,931		71
72 IMPL. DEV. CHARGED TO PATIENT				7,643		72
73 DRUGS CHARGED TO PATIENTS			1,148,367	105,529		73
76 CARDIAC REHAB	1,849			3,022		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	79,512					88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC	31,433					90
91 EMERGENCY	24,037	114,045		74,158		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	16,641	73,826				101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	425,276	936,524	1,148,367	1,158,122	51,032	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	1,849					194.02
194.03 WELLNESS	5,547					194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	432,672	936,524	1,148,367	1,158,122	51,032	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	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 STORES				5.03
5.04 ADMITTING				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL				5.06
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	3,975,621		3,975,621	30
43 NURSERY	134,719		134,719	43
44 SKILLED NURSING FACILITY	2,240,584		2,240,584	44
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	2,981,796		2,981,796	50
52 DELIVERY ROOM & LABOR ROOM	285,901		285,901	52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	2,485,971		2,485,971	54
54.01 RADIOLOGY-ULTRASOUND	349,595		349,595	54.01
60 LABORATORY	2,450,103		2,450,103	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	121,914		121,914	62
65 RESPIRATORY THERAPY	819,759		819,759	65
66 PHYSICAL THERAPY	1,757,072		1,757,072	66
69 ELECTROCARDIOLOGY	71,554		71,554	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,231,760		1,231,760	71
72 IMPL. DEV. CHARGED TO PATIENT	582,838		582,838	72
73 DRUGS CHARGED TO PATIENTS	2,667,145		2,667,145	73
76 CARDIAC REHAB	247,506		247,506	76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	4,856,469		4,856,469	88
88.01 RHC II	508,786		508,786	88.01
88.02 RHC III	476,221		476,221	88.02
90 CLINIC	2,056,562		2,056,562	90
91 EMERGENCY	2,322,519		2,322,519	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
101 HOME HEALTH AGENCY	808,731		808,731	101
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117)	33,433,126		33,433,126	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	32,746		32,746	190
192 PHYSICIANS' PRIVATE OFFICES	293,133		293,133	192
194 NONREIMBURSEABLE				194
194.01 PROFESSIONAL BUILDINGS	106,988		106,988	194.01
194.02 FOUNDATION SERVICES	68,901		68,901	194.02
194.03 WELLNESS	243,830		243,830	194.03
194.04 RENTED SPACE	85,455		85,455	194.04
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	34,264,179		34,264,179	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		17,078	4,230	21,308	21,308	4
5.01 NONPATIENT TELEPHONES			153	153	35	5.01
5.02 DATA PROCESSING		16,388	87,094	103,482	249	5.02
5.03 PURCHASING RECEIVING AND STORES		43,602	1,799	45,401	191	5.03
5.04 ADMITTING		14,416	1,964	16,380	375	5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE		23,842	2,348	26,190	365	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL		189,318	10,813	200,131	676	5.06
7 OPERATION OF PLANT		122,761	15,305	138,066	548	7
8 LAUNDRY & LINEN SERVICE		50,071	2,018	52,089	121	8
9 HOUSEKEEPING		14,435	918	15,353	407	9
10 DIETARY		66,064	17,768	83,832	273	10
11 CAFETERIA		38,771		38,771	314	11
13 NURSING ADMINISTRATION		9,012		9,012	827	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY		25,006	70,327	95,333	741	15
16 MEDICAL RECORDS & LIBRARY		61,292	14,957	76,249	766	16
17 SOCIAL SERVICE		986	195	1,181	39	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS		226,256	82,492	308,748	2,203	30
43 NURSERY		8,223		8,223	68	43
44 SKILLED NURSING FACILITY			6,831	6,831	925	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		209,334	128,341	337,675	1,178	50
52 DELIVERY ROOM & LABOR ROOM		24,670		24,670	126	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		66,991	55,995	122,986	869	54
54.01 RADIOLOGY-ULTRASOUND		9,565	247	9,812		54.01
60 LABORATORY		44,174	14,060	58,234	753	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		2,169		2,169		62
65 RESPIRATORY THERAPY		22,679	14,074	36,753	467	65
66 PHYSICAL THERAPY		197,660	9,507	207,167	814	66
69 ELECTROCARDIOLOGY		5,364	797	6,161	30	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		13,686		13,686		71
72 IMPL. DEV. CHARGED TO PATIENT		6,902		6,902		72
73 DRUGS CHARGED TO PATIENTS						73
76 CARDIAC REHAB		60,187	2,199	62,386	85	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)			35,597	35,597	4,361	88
88.01 RHC II			203	203	364	88.01
88.02 RHC III			3,037	3,037	376	88.02
90 CLINIC			30,233	30,233	990	90
91 EMERGENCY		189,318	26,113	215,431	903	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY			5,499	5,499	599	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)		1,780,220	645,114	2,425,334	21,038	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		13,804		13,804		190
192 PHYSICIANS' PRIVATE OFFICES					108	192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS						194.01
194.02 FOUNDATION SERVICES		986		986	35	194.02
194.03 WELLNESS			5,487	5,487	127	194.03
194.04 RENTED SPACE		78,370		78,370		194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)		1,873,380	650,601	2,523,981	21,308	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	NONPATIENT TELEPHONE S	DATA PROCESSING	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	188					5.01
5.02 DATA PROCESSING	2	103,733				5.02
5.03 PURCHASING RECEIVING AND STORES	3		45,595			5.03
5.04 ADMITTING	4		242	17,001		5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	5	65,383	48		91,991	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	8	38,350	630			5.06
7 OPERATION OF PLANT	3		824			7
8 LAUNDRY & LINEN SERVICE	1		339			8
9 HOUSEKEEPING	1		581			9
10 DIETARY	4		291			10
11 CAFETERIA						11
13 NURSING ADMINISTRATION	3		48			13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	5		388			15
16 MEDICAL RECORDS & LIBRARY	7		242			16
17 SOCIAL SERVICE	1					17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	23		1,308	3,962	5,042	30
43 NURSERY	1			395	437	43
44 SKILLED NURSING FACILITY	13		921			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	9		2,617	2,977	15,794	50
52 DELIVERY ROOM & LABOR ROOM				953	1,053	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	8		1,744	1,420	19,229	54
54.01 RADIOLOGY-ULTRASOUND				405	3,461	54.01
60 LABORATORY	4		6,396	2,073	18,918	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				171	363	62
65 RESPIRATORY THERAPY	3		533	729	2,318	65
66 PHYSICAL THERAPY	4		388	282	4,022	66
69 ELECTROCARDIOLOGY	1		48	150	807	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			15,120	1,271	2,597	71
72 IMPL. DEV. CHARGED TO PATIENT			7,607	287	585	72
73 DRUGS CHARGED TO PATIENTS				1,670	8,076	73
76 CARDIAC REHAB	1		48		231	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	28		2,035			88
88.01 RHC II	4		339			88.01
88.02 RHC III	3		242			88.02
90 CLINIC	23		1,405	3	2,222	90
91 EMERGENCY	6		727	253	5,676	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	5		388		1,160	101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	183	103,733	45,499	17,001	91,991	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192 PHYSICIANS' PRIVATE OFFICES						192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	3					194.01
194.02 FOUNDATION SERVICES	1		48			194.02
194.03 WELLNESS	1		48			194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	188	103,733	45,595	17,001	91,991	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II.

COST CENTER DESCRIPTION	OTHER ADMI NISTRATIVE AND GENER 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	239,795					5.06
7 OPERATION OF PLANT	12,946	152,387				7
8 LAUNDRY & LINEN SERVICE	1,600	4,145	58,295			8
9 HOUSEKEEPING	3,949	1,195		21,486		9
10 DIETARY	3,827	5,469	1,093	679	95,468	10
11 CAFETERIA	2,680	3,210		398		11
13 NURSING ADMINISTRATION	6,357	746		93		13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	7,323	2,070		257		15
16 MEDICAL RECORDS & LIBRARY	7,348	5,074		630		16
17 SOCIAL SERVICE	290	82		10		17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	20,457	18,730	21,611	2,324	32,792	30
43 NURSERY	716	681	528	84		43
44 SKILLED NURSING FACILITY	9,118	17,773	17,706	2,205	53,329	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	16,043	17,330	7,232	2,150	902	50
52 DELIVERY ROOM & LABOR ROOM	1,467	2,042	688	253		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	14,783	5,546	2,915	688		54
54.01 RADIOLOGY-ULTRASOUND	2,044	792		98		54.01
60 LABORATORY	14,877	3,657	36	454		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	801	180		22		62
65 RESPIRATORY THERAPY	4,804	1,878	401	233		65
66 PHYSICAL THERAPY	9,970	16,364	1,303	2,030		66
69 ELECTROCARDIOLOGY	379	444		55		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	8,260	1,133		141		71
72 IMPL. DEV. CHARGED TO PATIENT	3,963	571		71		72
73 DRUGS CHARGED TO PATIENTS	9,890					73
76 CARDIAC REHAB	1,158	4,983		618		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	32,899		545	2,746		88
88.01 RHC II	3,559		55			88.01
88.02 RHC III	3,332		22			88.02
90 CLINIC	12,442	15,696	894	1,948		90
91 EMERGENCY	12,586	15,673	2,679	1,945	8,445	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	5,009			91		101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	234,877	145,464	57,708	20,223	95,468	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	105	1,143		142		190
192 PHYSICIANS' PRIVATE OFFICES	2,051					192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS	673			404		194.01
194.02 FOUNDATION SERVICES	460	82		10		194.02
194.03 WELLNESS	1,031	5,698	587	707		194.03
194.04 RENTED SPACE	598					194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	239,795	152,387	58,295	21,486	95,468	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
	11	13	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
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	45,373					11
13 NURSING ADMINISTRATION	1,745	18,831				13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	1,357	1,146	108,620			15
16 MEDICAL RECORDS & LIBRARY	3,102			93,418		16
17 SOCIAL SERVICE	194	131			1,928	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	6,399	5,791		5,314	964	30
43 NURSERY	194	238		460		43
44 SKILLED NURSING FACILITY	3,684	3,246			964	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	3,296	2,870		16,648		50
52 DELIVERY ROOM & LABOR ROOM	582	443		1,110		52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	2,327			20,289		54
54.01 RADIOLOGY-ULTRASOUND				3,648		54.01
60 LABORATORY	2,133			19,940		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS				383		62
65 RESPIRATORY THERAPY	1,357	1,189		2,443		65
66 PHYSICAL THERAPY	2,133			4,239		66
69 ELECTROCARDIOLOGY				851		69
71 MEDICAL SUPPLIES CHRGED TO PATIENTS				2,737		71
72 IMPL. DEV. CHARGED TO PATIENT				617		72
73 DRUGS CHARGED TO PATIENTS			108,620	8,513		73
76 CARDIAC REHAB	194			244		76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	8,338					88
88.01 RHC II						88.01
88.02 RHC III						88.02
90 CLINIC	3,296					90
91 EMERGENCY	2,521	2,293		5,982		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	1,745	1,484				101
SPECIAL PURPOSE COST CENTERS						
113 INTEREST EXPENSE						113
118 SUBTOTALS (SUM OF LINES 1-117)	44,597	18,831	108,620	93,418	1,928	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					194.02
194.03 WELLNESS	582					194.03
194.04 RENTED SPACE						194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	45,373	18,831	108,620	93,418	1,928	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	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 STORES				5.03
5.04 ADMITTING				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE				5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL				5.06
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY				16
17 SOCIAL SERVICE				17
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	435,668		435,668	30
43 NURSERY	12,025		12,025	43
44 SKILLED NURSING FACILITY	116,715		116,715	44
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	426,721		426,721	50
52 DELIVERY ROOM & LABOR ROOM	33,387		33,387	52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	192,804		192,804	54
54.01 RADIOLOGY-ULTRASOUND	20,260		20,260	54.01
60 LABORATORY	127,475		127,475	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	4,089		4,089	62
65 RESPIRATORY THERAPY	53,108		53,108	65
66 PHYSICAL THERAPY	248,716		248,716	66
69 ELECTROCARDIOLOGY	8,926		8,926	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	44,945		44,945	71
72 IMPL. DEV. CHARGED TO PATIENT	20,603		20,603	72
73 DRUGS CHARGED TO PATIENTS	136,769		136,769	73
76 CARDIAC REHAB	69,948		69,948	76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	86,549		86,549	88
88.01 RHC II	4,524		4,524	88.01
88.02 RHC III	7,012		7,012	88.02
90 CLINIC	69,152		69,152	90
91 EMERGENCY	275,120		275,120	91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
101 HOME HEALTH AGENCY	15,980		15,980	101
SPECIAL PURPOSE COST CENTERS				
113 INTEREST EXPENSE				113
118 SUBTOTALS (SUM OF LINES 1-117)	2,410,496		2,410,496	118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,194		15,194	190
192 PHYSICIANS' PRIVATE OFFICES	2,159		2,159	192
194 NONREIMBURSEABLE				194
194.01 PROFESSIONAL BUILDINGS	1,080		1,080	194.01
194.02 FOUNDATION SERVICES	1,816		1,816	194.02
194.03 WELLNESS	14,268		14,268	194.03
194.04 RENTED SPACE	78,968		78,968	194.04
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 TOTAL (SUM OF LINES 118-201)	2,523,981		2,523,981	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME
	1	2	4	5.01	5.02
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT	94,996				1
2 CAP REL COSTS-MVBLE EQUIP		971,812			2
4 EMPLOYEE BENEFITS	866	6,318	15,735,776		4
5.01 NONPATIENT TELEPHONES		228	25,877	365	5.01
5.02 DATA PROCESSING	831	130,093	183,597	3	5.02
5.03 PURCHASING RECEIVING AND STORES	2,211	2,687	140,913	6	5.03
5.04 ADMITTING	731	2,934	276,595	8	5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	1,209	3,507	269,714	10	5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	9,600	16,152	499,001	15	5.06
7 OPERATION OF PLANT	6,225	22,861	404,537	6	7
8 LAUNDRY & LINEN SERVICE	2,539	3,015	89,595	1	8
9 HOUSEKEEPING	732	1,371	300,887	1	9
10 DIETARY	3,350	26,541	201,919	8	10
11 CAFETERIA	1,966		231,746		11
13 NURSING ADMINISTRATION	457		610,617	6	13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY	1,268	105,048	547,365	9	15
16 MEDICAL RECORDS & LIBRARY	3,108	22,341	565,542	13	16
17 SOCIAL SERVICE	50	291	28,648	2	17
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	11,473	123,220	1,626,906	44	30
43 NURSERY	417		49,935	1	43
44 SKILLED NURSING FACILITY		10,203	683,072	26	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	10,615	191,708	869,735	18	50
52 DELIVERY ROOM & LABOR ROOM	1,251		93,053		52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	3,397	83,640	641,857	15	54
54.01 RADIOLOGY-ULTRASOUND	485	369			54.01
60 LABORATORY	2,240	21,001	556,223	7	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS	110				62
65 RESPIRATORY THERAPY	1,150	21,022	345,074	5	65
66 PHYSICAL THERAPY	10,023	14,201	601,313	7	66
69 ELECTROCARDIOLOGY	272	1,191	21,929	2	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	694				71
72 IMPL. DEV. CHARGED TO PATIENT	350				72
73 DRUGS CHARGED TO PATIENTS					73
76 CARDIAC REHAB	3,052	3,284	62,600	2	76
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		53,172	3,219,869	66	88
88.01 RHC II		303	268,998	7	88.01
88.02 RHC III		4,536	277,767	6	88.02
90 CLINIC		45,160	731,506	44	90
91 EMERGENCY	9,600	39,005	667,276	11	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
101 HOME HEALTH AGENCY		8,214	442,665	9	101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	90,272	963,616	15,536,331	358	10,000 118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	700				190
192 PHYSICIANS' PRIVATE OFFICES			79,702		192
194 NONREIMBURSEABLE					194
194.01 PROFESSIONAL BUILDINGS				5	194.01
194.02 FOUNDATION SERVICES	50		25,615	1	194.02
194.03 WELLNESS		8,196	94,128	1	194.03
194.04 RENTED SPACE	3,974				194.04
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	1,873,380	650,601	3,003,589	36,365	965,739 202
203 UNIT COST MULT-WS B PT I	19.720620	0.669472	0.190876	99.630137	96.573900 203
204 COST TO BE ALLOC PER B PT II			21,308	188	103,733 204
205 UNIT COST MULT-WS B PT II			0.001354	0.515068	10.373300 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 ADMI NISTRATIVE AND GENER 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	941					5.03
5.04 ADMITTING	5	13,537,779				5.04
5.05 CASHIERING/ACCOUNTS RECEIVABLE	1		66,293,810			5.05
5.06 OTHER ADMINISTRATIVE AND GENERAL	13			-2,840,705	31,423,474	5.06
7 OPERATION OF PLANT	17				1,696,545	7
8 LAUNDRY & LINEN SERVICE	7				209,681	8
9 HOUSEKEEPING	12				517,448	9
10 DIETARY	6				501,531	10
11 CAFETERIA					351,228	11
13 NURSING ADMINISTRATION	1				833,026	13
14 CENTRAL SERVICES & SUPPLY						14
15 PHARMACY	8				959,612	15
16 MEDICAL RECORDS & LIBRARY	5				962,931	16
17 SOCIAL SERVICE					37,956	17
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	27	3,157,039	3,632,223		2,680,796	30
43 NURSERY		314,589	314,589		93,803	43
44 SKILLED NURSING FACILITY	19				1,194,875	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	54	2,370,207	11,379,022		2,102,285	50
52 DELIVERY ROOM & LABOR ROOM		758,416	758,383		192,282	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	36	1,130,253	13,872,691		1,937,243	54
54.01 RADIOLOGY-ULTRASOUND		322,521	2,493,187		267,902	54.01
60 LABORATORY	132	1,650,153	13,629,827		1,949,542	60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS		136,279	261,822		104,903	62
65 RESPIRATORY THERAPY	11	580,225	1,669,992		629,492	65
66 PHYSICAL THERAPY	8	224,224	2,897,413		1,306,499	66
69 ELECTROCARDIOLOGY	1	119,524	581,625		49,643	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	312	1,011,888	1,870,919		1,082,434	71
72 IMPL. DEV. CHARGED TO PATIENT	157	228,815	421,448		519,394	72
73 DRUGS CHARGED TO PATIENTS		1,329,635	5,818,745		1,296,082	73
76 CARDIAC REHAB	1	305	166,613		151,772	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	42				4,310,746	88
88.01 RHC II	7				466,364	88.01
88.02 RHC III	5				436,642	88.02
90 CLINIC	29	2,203	1,600,831		1,630,455	90
91 EMERGENCY	15	201,503	4,088,991		1,649,380	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	8		835,489		656,464	101
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	939	13,537,779	66,293,810	-2,840,705	30,778,956	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN					13,804	190
192 PHYSICIANS' PRIVATE OFFICES					268,830	192
194 NONREIMBURSEABLE						194
194.01 PROFESSIONAL BUILDINGS					88,130	194.01
194.02 FOUNDATION SERVICES	1				60,334	194.02
194.03 WELLNESS	1				135,050	194.03
194.04 RENTED SPACE					78,370	194.04
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	251,802	389,911	1,294,644		2,840,705	202
203 UNIT COST MULT-WS B PT I	267.589798	0.028802	0.019529		0.090401	203
204 COST TO BE ALLOC PER B PT II	45,595	17,001	91,991		239,795	204
205 UNIT COST MULT-WS B PT II	48.453773	0.001256	0.001388		0.007631	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA 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
7	OPERATION OF PLANT	93,339				7
8	LAUNDRY & LINEN SERVICE	2,539	197,865			8
9	HOUSEKEEPING	732		106,061		9
10	DIETARY	3,350	3,710	3,350	48,499	10
11	CAFETERIA	1,966		1,966		11
13	NURSING ADMINISTRATION	457		457		13
14	CENTRAL SERVICES & SUPPLY				234	14
15	PHARMACY	1,268		1,268	9	15
16	MEDICAL RECORDS & LIBRARY	3,108		3,108	7	16
17	SOCIAL SERVICE	50		50	16	17
INFAPIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	11,473	73,353	11,473	16,659	33
43	NURSERY	417	1,792	417		1
44	SKILLED NURSING FACILITY	10,886	60,097	10,886	27,092	19
ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	10,615	24,548	10,615	458	17
52	DELIVERY ROOM & LABOR ROOM	1,251	2,335	1,251		3
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC	3,397	9,895	3,397		12
54.01	RADIOLOGY-ULTRASOUND	485		485		54.01
60	LABORATORY	2,240	122	2,240		11
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	110		110		62
65	RESPIRATORY THERAPY	1,150	1,360	1,150		7
66	PHYSICAL THERAPY	10,023	4,424	10,023		11
69	ELECTROCARDIOLOGY	272		272		69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	694		694		71
72	IMPL. DEV. CHARGED TO PATIENT	350		350		72
73	DRUGS CHARGED TO PATIENTS					73
76	CARDIAC REHAB	3,052		3,052		1
OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC (RHC)		1,849	13,547		43
88.01	RHC II		186			88.01
88.02	RHC III		75			88.02
90	CLINIC	9,614	3,033	9,614		17
91	EMERGENCY	9,600	9,092	9,600	4,290	13
92	OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS						
101	HOME HEALTH AGENCY			450		9
SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (SUM OF LINES 1-117)	89,099	195,871	99,825	48,499	230
NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	700		700		190
192	PHYSICIANS' PRIVATE OFFICES					192
194	NONREIMBURSEABLE					194
194.01	PROFESSIONAL BUILDINGS			1,996		194.01
194.02	FOUNDATION SERVICES	50		50		1
194.03	WELLNESS	3,490	1,994	3,490		3
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	1,849,914	278,957	578,734	636,775	432,672
203	UNIT COST MULT-WS B PT I	19.819304	1.409835	5.456615	13.129652	1,849.025641
204	COST TO BE ALLOC PER B PT II	152,387	58,295	21,486	95,468	45,373
205	UNIT COST MULT-WS B PT II	1.632619	0.294620	0.202582	1.968453	193.901709

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NURSING ADMINIS- TRATION NURSING HOURS 13	PHARMACY RX CSTD REQ'S 15	MEDICAL RECORDS & LIBRARY GROSS REVENUE 16	SOCIAL SERVICE TIME 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
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
13 NURSING ADMINISTRATION	225,967				13
14 CENTRAL SERVICES & SUPPLY					14
15 PHARMACY	13,756	1,130,724			15
16 MEDICAL RECORDS & LIBRARY			63,857,487		16
17 SOCIAL SERVICE	1,576			100	17
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS	69,474		3,632,223	50	30
43 NURSERY	2,851		314,586		43
44 SKILLED NURSING FACILITY	38,956			50	44
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	34,439		11,379,022		50
52 DELIVERY ROOM & LABOR ROOM	5,314		758,383		52
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC			13,872,691		54
54.01 RADIOLOGY-ULTRASOUND			2,493,187		54.01
60 LABORATORY			13,629,827		60
62 WHOLE BLOOD & PACKED RED BLOOD CELLS			261,822		62
65 RESPIRATORY THERAPY	14,271		1,669,992		65
66 PHYSICAL THERAPY			2,897,413		66
69 ELECTROCARDIOLOGY			581,625		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			1,870,919		71
72 IMPL. DEV. CHARGED TO PATIENT			421,448		72
73 DRUGS CHARGED TO PATIENTS		1,130,724	5,818,745		73
76 CARDIAC REHAB			166,613		76
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	27,517		4,088,991		91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
101 HOME HEALTH AGENCY	17,813				101
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	225,967	1,130,724	63,857,487	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
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	936,524	1,148,367	1,158,122	51,032	202
203 UNIT COST MULT-WS B PT I	4.144517	1.015603	0.018136	510.320000	203
204 COST TO BE ALLOC PER B PT II	18,831	108,620	93,418	1,928	204
205 UNIT COST MULT-WS B PT II	0.083335	0.096062	0.001463	19.280000	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	3,975,621		3,975,621		3,975,621	30
43 NURSERY	134,719		134,719		134,719	43
44 SKILLED NURSING FACILITY	2,240,584		2,240,584		2,240,584	44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,981,796		2,981,796		2,981,796	50
52 DELIVERY ROOM & LABOR ROOM	285,901		285,901		285,901	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	2,485,971		2,485,971		2,485,971	54
54.01 RADIOLOGY-ULTRASOUND	349,595		349,595		349,595	54.01
60 LABORATORY	2,450,103		2,450,103		2,450,103	60
62 WHOLE BLOOD & PACKED RED BL	121,914		121,914		121,914	62
65 RESPIRATORY THERAPY	819,759		819,759		819,759	65
66 PHYSICAL THERAPY	1,757,072		1,757,072		1,757,072	66
69 ELECTROCARDIOLOGY	71,554		71,554		71,554	69
71 MEDICAL SUPPLIES CHRGED TO	1,231,760		1,231,760		1,231,760	71
72 IMPL. DEV. CHARGED TO PATIE	582,838		582,838		582,838	72
73 DRUGS CHARGED TO PATIENTS	2,667,145		2,667,145		2,667,145	73
76 CARDIAC REHAB	247,506		247,506		247,506	76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	4,856,469		4,856,469		4,856,469	88
88.01 RHC II	508,786		508,786		508,786	88.01
88.02 RHC III	476,221		476,221		476,221	88.02
90 CLINIC	2,056,562		2,056,562		2,056,562	90
91 EMERGENCY	2,322,519		2,322,519		2,322,519	91
92 OBSERVATION BEDS	405,512		405,512		405,512	92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY	808,731		808,731		808,731	101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	33,838,638		33,838,638		33,838,638	200
201 LESS OBSERVATION BEDS	405,512		405,512		405,512	201
202 TOTAL (SEE INSTRUCTIONS)	33,433,126		33,433,126		33,433,126	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	3,220,078		3,220,078			30
43 NURSERY	314,589		314,589			43
44 SKILLED NURSING FACILITY	1,186,811		1,186,811			44
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	2,370,207	9,008,814	11,379,021	0.262043	0.262043	0.262043 50
52 DELIVERY ROOM & LABOR ROOM	728,383	30,000	758,383	0.376988	0.376988	0.376988 52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,130,253	12,742,438	13,872,691	0.179199	0.179199	0.179199 54
54.01 RADIOLOGY-ULTRASOUND	322,521	2,170,666	2,493,187	0.140220	0.140220	0.140220 54.01
60 LABORATORY	1,650,153	11,979,674	13,629,827	0.179760	0.179760	0.179760 60
62 WHOLE BLOOD & PACKED RED BL	136,279	125,543	261,822	0.465637	0.465637	0.465637 62
65 RESPIRATORY THERAPY	580,225	1,089,767	1,669,992	0.490876	0.490876	0.490876 65
66 PHYSICAL THERAPY	424,224	2,473,189	2,897,413	0.606428	0.606428	0.606428 66
69 ELECTROCARDIOLOGY	119,524	462,101	581,625	0.123024	0.123024	0.123024 69
71 MEDICAL SUPPLIES CHRGD TO	1,011,888	859,031	1,870,919	0.658372	0.658372	0.658372 71
72 IMPL. DEV. CHARGED TO PATIE	188,815	232,633	421,448	1.382942	1.382942	1.382942 72
73 DRUGS CHARGED TO PATIENTS	1,329,635	4,489,110	5,818,745	0.458371	0.458371	0.458371 73
76 CARDIAC REHAB	305	166,308	166,613	1.485514	1.485514	1.485514 76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		5,788,779	5,788,779			88
88.01 RHC II		594,451	594,451			88.01
88.02 RHC III		503,431	503,431			88.02
90 CLINIC	92,203	1,508,627	1,600,830	1.284685	1.284685	1.284685 90
91 EMERGENCY	201,503	3,887,488	4,088,991	0.567993	0.567993	0.567993 91
92 OBSERVATION BEDS	20,000	392,145	412,145	0.983906	0.983906	0.983906 92
OTHER REIMBURSABLE COST CENTERS						
101 HOME HEALTH AGENCY		835,489	835,489			101
113 INTEREST EXPENSE						113
200 SUBTOTAL (SEE INSTRUCTIONS)	15,027,596	59,339,684	74,367,280			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	15,027,596	59,339,684	74,367,280			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

[] S/B-SNF
 [] S/B-NF
 [] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS			
		PPS REIMBURSED SERVICES 2	COST REIMB. COST REIMB.		PPS SERVICES 5	COST			
			SUBJECT TO DED. & COINS 3	SVCES NOT SUBJECT TO DED. & COINS 4		SUBJECT TO DED. & COINS 6	SVCES NOT SUBJECT TO DED. & COINS 7		
50 ANCILLARY SERVICE COST CENTERS								50	
52 OPERATING ROOM	0.262043		2,412,767			632,249		52	
53 DELIVERY ROOM & LABOR ROOM	0.376988							53	
54 ANESTHESIOLOGY								54	
54.01 RADIOLOGY-DIAGNOSTIC	0.179199		4,179,985			749,049		54.01	
60 RADIOLOGY-ULTRASOUND	0.140220		643,281			90,201			
62 LABORATORY	0.179760		5,177,042			930,625		60	
65 WHOLE BLOOD & PACKED RED BLOOD	0.465637		63,586			29,608		62	
66 RESPIRATORY THERAPY	0.490876		435,130			213,595		65	
69 PHYSICAL THERAPY	0.606428		818,628			496,439		66	
71 ELECTROCARDIOLOGY	0.123024		270,287			33,252		69	
72 MEDICAL SUPPLIES CHRGD TO PATI	0.658372		208,362			137,180		71	
73 IMPL. DEV. CHARGED TO PATIENT	1.382942		209,247			289,376		72	
76 DRUGS CHARGED TO PATIENTS	0.458371		2,210,432			1,013,198		73	
88 CARDIAC REHAB	1.485514		23,765			35,303		76	
88.01 OUTPATIENT SERVICE COST CENTERS								88	
88.02 RURAL HEALTH CLINIC (RHC)								88.01	
90 RHC II								88.02	
91 RHC III								90	
92 CLINIC	1.284685		528,581			679,060		91	
EMERGENCY	0.567993		1,245,220			707,276		92	
OBSERVATION BEDS	0.983906		202,287			199,031			
200 OTHER REIMBURSABLE COST CENTERS								200	
201 SUBTOTAL (SEE INSTRUCTIONS)			18,628,600			6,235,442		201	
202 LESS PBP CLINIC LAB SERVICES								202	
NET CHARGES (LINE 200 - LINE 201)			18,628,600			6,235,442			

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	
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 ÷ COL.4)		CAP COST (COL.5 x COL.6)	
	1	2	3		5		6	7
30 INPAT ROUTINE SERV COST CTRS								
31 ADULTS & PEDIATRICS	435,668	26,094	409,574	3,954	103.58	499	51,686	30
32 INTENSIVE CARE UNIT								31
33 CORONARY CARE UNIT								32
34 BURN INTENSIVE CARE UNIT								33
35 SURGICAL INTENSIVE CARE UNIT								34
40 OTHER SPECIAL CARE (SPECIFY)								35
41 SUBPROVIDER - IPF								40
42 SUBPROVIDER - IRF								41
43 SUBPROVIDER I								42
44 NURSERY	12,025		12,025	365	32.95	253	8,336	43
45 SKILLED NURSING FACILITY	116,715		116,715	7,615	15.33			44
200 NURSING FACILITY								45
200 TOTAL (LINES 30-199)	564,408		538,314	11,934		752	60,022	200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

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

COST CENTER DESCRIPTION	CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5	
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	426,721	11,379,021	0.037501	494,413	18,541	50
52 DELIVERY ROOM & LABOR ROOM	33,387	758,383	0.044024	278,446	12,258	52
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	192,804	13,872,691	0.013898	205,862	2,861	54
54.01 RADIOLOGY-ULTRASOUND	20,260	2,493,187	0.008126	57,378	466	54.01
60 LABORATORY	127,475	13,629,827	0.009353	281,332	2,631	60
62 WHOLE BLOOD & PACKED RED BLOO	4,089	261,822	0.015617			62
65 RESPIRATORY THERAPY	53,108	1,669,992	0.031801	45,136	1,435	65
66 PHYSICAL THERAPY	248,716	2,897,413	0.085841	8,986	771	66
69 ELECTROCARDIOLOGY	8,926	581,625	0.015347	9,646	148	69
71 MEDICAL SUPPLIES CHRGED TO PA	44,945	1,870,919	0.024023	89,662	2,154	71
72 IMPL. DEV. CHARGED TO PATIENT	20,603	421,448	0.048886			72
73 DRUGS CHARGED TO PATIENTS	136,769	5,818,745	0.023505	88,909	2,090	73
76 CARDIAC REHAB	69,948	166,613	0.419823			76
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	86,549	5,788,779	0.014951			88
88.01 RHC II	4,524	594,451	0.007610			88.01
88.02 RHC III	7,012	503,431	0.013928			88.02
90 CLINIC	69,152	1,600,830	0.043198	668	29	90
91 EMERGENCY	275,120	4,088,991	0.067283	51,309	3,452	91
92 OBSERVATION BEDS	47,269	412,145	0.114690	12,427	1,425	92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)	1,877,377	68,810,313		1,624,174	48,261	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 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.262043		1,548,186			405,691		50
52 DELIVERY ROOM & LABOR ROOM	0.376988		25,714			9,694		52
53 ANESTHESIOLOGY								53
54 RADIOLOGY-DIAGNOSTIC	0.179199		2,759,143			494,436		54
54.01 RADIOLOGY-ULTRASOUND	0.140220		565,003			79,225		54.01
60 LABORATORY	0.179760		1,890,588			339,852		60
62 WHOLE BLOOD & PACKED RED BLOOD	0.465637							62
65 RESPIRATORY THERAPY	0.490876		111,567			54,766		65
66 PHYSICAL THERAPY	0.606428		342,749			207,853		66
69 ELECTROCARDIOLOGY	0.123024		147,408			18,135		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.658372		183,461			120,786		71
72 IMPL. DEV. CHARGED TO PATIENT	1.382942		15,554			21,510		72
73 DRUGS CHARGED TO PATIENTS	0.458371		95,197			43,636		73
76 CARDIAC REHAB	1.485514		873			1,297		76
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
88.01 RHC II								88.01
88.02 RHC III								88.02
90 CLINIC	1.284685		148,669			190,993		90
91 EMERGENCY	0.567993		970,043			550,978		91
92 OBSERVATION BEDS	0.983906		51,172			50,348		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			8,855,327			2,589,200		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			8,855,327			2,589,200		202

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

CHECK TITLE V-INPT HOSPITAL (14-1343) SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF TEFRA
 BOXES 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)	4,232 1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,954 2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	228 3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,297 4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	165 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)	83 6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	20 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)	10 8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	1,944 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)	165 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)	83 11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	16
SWING-BED ADJUSTMENT		
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	122.61 19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	124.59 20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,975,621 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)	2,452 24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	1,246 25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	238,120 26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,737,501 27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,587,945 28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	199,380 29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,388,565 30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.444196 31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	874.47 32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	724.47 33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	150.00 34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	216.63 35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	49,392 36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,688,109 37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

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

[] PPS
 [] TEFRA
 [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

38	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					
	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS)				932.75	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38)				1,813,266	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)				1,813,266	41

	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (COL. 1 ÷ COL. 2)	PROGRAM DAYS	PROGRAM COST (COL. 3 x COL. 4)	
	1	2	3	4	5	
42	NURSERY (TITLES V AND XIX ONLY)					42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT					43
44	CORONARY CARE UNIT					44
45	BURN INTENSIVE CARE UNIT					45
46	SURGICAL INTENSIVE CARE UNIT					46
47	OTHER SPECIAL CARE (SPECIFY)					47
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)				1,675,266	48
49	TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)				3,488,532	49

50	PASS-THROUGH COST ADJUSTMENTS					
	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 THE MARKET BASKET					59
60	LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET					60
61	IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS)					61
62	RELIEF PAYMENT (SEE INSTRUCTIONS)					62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)					63

	PROGRAM INPATIENT ROUTINE SWING BED COST					
64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)				153,904	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY)				77,418	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS)				231,322	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)				429	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2)				945.25	88
89	OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS)				405,512	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	
90	CAPITAL-RELATED COST	435,668	3,737,501	0.116567	405,512	47,269 90
91	NURSING SCHOOL COST					91
92	ALLIED HEALTH COST					92
93	ALL OTHER MEDICAL EDUCATION					93

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

CHECK TITLE V-INPT HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF (14-6150) TEFRA
 BOXES 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)	7,615	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	7,615	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	7,615	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	896	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	2,240,584	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,240,584	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	1,186,811	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	1,186,811	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.887903	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	155.85	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	2,240,584	37

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 08:40

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PARTS III & IV

CHECK TITLE V-INPT HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF (14-6150) TEFRA
 BOXES TITLE XIX-INPT IRF NF OTHER

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COSTS (LINE 37)	2,240,584	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (LINE 70 ÷ LINE 2)	294.23	71
72	PROGRAM ROUTINE SERVICE COST (LINE 9 x LINE 71)	263,630	72
73	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM (LINE 14 x LINE 35)		73
74	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS (LINE 72 + LINE 73)	263,630	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (FROM WKST B, PART II, COL. 26, LINE 45)		75
76	PER DIEM CAPITAL-RELATED COSTS (LINE 75 ÷ LINE 2)		76
77	PROGRAM CAPITAL-RELATED COSTS (LINE 9 x LINE 76)		77
78	INPATIENT ROUTINE SERVICE COST (LINE 74 MINUS LINE 77)		78
79	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS (FROM PROVIDER RECORDS)		79
80	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION (LINE 78 MINUS LINE 79)		80
81	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION		81
82	INPATIENT ROUTINE SERVICE COST LIMITATION (LINE 9 x LINE 81)		82
83	REASONABLE INPATIENT ROUTINE SERVICE COSTS (SEE INSTRUCTIONS)	263,630	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (SEE INSTRUCTIONS)	158,649	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (SEE INSTRUCTIONS)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (SUM OF LINES 83 THROUGH 85)	422,279	86

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART I

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)	4,232	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,954	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	228	3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,297	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	165	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)	83	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	20	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)	10	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	499	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)	365	15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)	253	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	122.61	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	124.59	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,975,621	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)	2,452	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)	1,246	25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	238,120	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,737,501	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,587,945	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	199,380	29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,388,565	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1,444,196	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)	874.47	32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	724.47	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)	150.00	34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)	216.63	35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)	49,392	36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,688,109	37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1
 PART II

CHECK [] TITLE V-INPT [XX] HOSPITAL (14-1343) [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII-PT A [] IPF [] TEFRA
 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) 945.25 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 471,680 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) 471,680 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)	134,719	365	369.09	253	93,380 42

INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS
 43 INTENSIVE CARE UNIT 43
 44 CORONARY CARE UNIT 44
 45 BURN INTENSIVE CARE UNIT 45
 46 SURGICAL INTENSIVE CARE UNIT 46
 47 OTHER SPECIAL CARE (SPECIFY) 47
 48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200) 500,840 48
 49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS) 1,065,900 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 60,022 50
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 48,261 51
 52 TOTAL PROGRAM EXCLUDABLE COST 108,283 52
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 957,617 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 THE MARKET BASKET 59
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 429 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 HOSPITAL (14-1343) SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF S/B NF TEFFRA
 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
30 INPATIENT ROUTINE SERVICE COST CENTERS				
ADULTS & PEDIATRICS		1,715,821		30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.262043	545,817	143,028	50
52 DELIVERY ROOM & LABOR ROOM	0.376988			52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.179199	704,743	126,289	54
54.01 RADIOLOGY-ULTRASOUND	0.140220	210,898	29,572	54.01
60 LABORATORY	0.179760	912,394	164,012	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.465637	83,337	38,805	62
65 RESPIRATORY THERAPY	0.490876	315,732	154,985	65
66 PHYSICAL THERAPY	0.606428	117,315	71,143	66
69 ELECTROCARDIOLOGY	0.123024	93,577	11,512	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.658372	541,212	356,319	71
72 IMPL. DEV. CHARGED TO PATIENT	1.382942	122,099	168,856	72
73 DRUGS CHARGED TO PATIENTS	0.458371	688,073	315,393	73
76 CARDIAC REHAB	1.485514			76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	1.284685	72,543	93,195	90
91 EMERGENCY	0.567993	824	468	91
92 OBSERVATION BEDS	0.983906	1,717	1,689	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,410,281	1,675,266	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,410,281		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] S/B SNF (14-Z343) [] 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				30
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.262043			50
52 DELIVERY ROOM & LABOR ROOM	0.376988			52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.179199	10,424	1,868	54
54.01 RADIOLOGY-ULTRASOUND	0.140220	1,142	160	54.01
60 LABORATORY	0.179760	33,107	5,951	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.465637			62
65 RESPIRATORY THERAPY	0.490876	14,568	7,151	65
66 PHYSICAL THERAPY	0.606428	72,710	44,093	66
69 ELECTROCARDIOLOGY	0.123024	645	79	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.658372	20,038	13,192	71
72 IMPL. DEV. CHARGED TO PATIENT	1.382942			72
73 DRUGS CHARGED TO PATIENTS	0.458371	27,476	12,594	73
76 CARDIAC REHAB	1.485514			76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	1.284685	66	85	90
91 EMERGENCY	0.567993			91
92 OBSERVATION BEDS	0.983906			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		180,176	85,173	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		180,176		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK TITLE V HOSPITAL SUB (OTHER) S/B SNF PPS
 APPLICABLE TITLE XVIII-PT A IPF SNF (14-6150) 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
30 INPATIENT ROUTINE SERVICE COST CENTERS				30
ADULTS & PEDIATRICS				
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.262043			50
52 DELIVERY ROOM & LABOR ROOM	0.376988			52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.179199	11,658	2,089	54
54.01 RADIOLOGY-ULTRASOUND	0.140220	3,899	547	54.01
60 LABORATORY	0.179760	30,651	5,510	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.465637	3,968	1,848	62
65 RESPIRATORY THERAPY	0.490876	22,376	10,984	65
66 PHYSICAL THERAPY	0.606428	198,284	120,245	66
69 ELECTROCARDIOLOGY	0.123024	430	53	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.658372	4,833	3,182	71
72 IMPL. DEV. CHARGED TO PATIENT	1.382942			72
73 DRUGS CHARGED TO PATIENTS	0.458371	30,959	14,191	73
76 CARDIAC REHAB	1.485514			76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	1.284685			90
91 EMERGENCY	0.567993			91
92 OBSERVATION BEDS	0.983906			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		307,058	158,649	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		307,058		202

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

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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 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		398,863		30
43 NURSERY		186,131		43
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.262043	494,413	129,557	50
52 DELIVERY ROOM & LABOR ROOM	0.376988	278,446	104,971	52
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.179199	205,862	36,890	54
54.01 RADIOLOGY-ULTRASOUND	0.140220	57,378	8,046	54.01
60 LABORATORY	0.179760	281,332	50,572	60
62 WHOLE BLOOD & PACKED RED BLOOD	0.465637			62
65 RESPIRATORY THERAPY	0.490876	45,136	22,156	65
66 PHYSICAL THERAPY	0.606428	8,986	5,449	66
69 ELECTROCARDIOLOGY	0.123024	9,646	1,187	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.658372	89,662	59,031	71
72 IMPL. DEV. CHARGED TO PATIENT	1.382942			72
73 DRUGS CHARGED TO PATIENTS	0.458371	88,909	40,753	73
76 CARDIAC REHAB	1.485514			76
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
88.01 RHC II				88.01
88.02 RHC III				88.02
90 CLINIC	1.284685	668	858	90
91 EMERGENCY	0.567993	51,309	29,143	91
92 OBSERVATION BEDS	0.983906	12,427	12,227	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		1,624,174	500,840	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		1,624,174		202

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM VERSION: 2012.11
 IN LIEU OF FORM CMS-2552-10 (08/2011) 09/23/2013 08:40

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [XX] 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	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,774,115		3,976,561	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 10/18/2012	48,741		NONE	3.01
	.02 03/13/2013	14,376			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	10/18/2012	57,313	3.50
.51			03/13/2013	11,928	3.51
PROVIDER .52					3.52
TO .53					3.53
PROGRAM .54					3.54
.55					3.55
.56					3.56
.57					3.57
.58					3.58
.59					3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	63,117		-69,241	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		2,837,232		3,907,320	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
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99				5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	287,582		124,304	6.01
	TO PROVIDER				
	PROVIDER				
	TO .02				6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		3,124,814		4,031,624	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

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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 (14-2343)	INPATIENT		PART B		AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
			MM/DD/YYYY 1							
DESCRIPTION										
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER							296,192			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	10/18/2012				6,726		NONE	3.01
		.02	03/13/2013				4,957			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					11,683			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)							307,875			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					11,785			6.01
		PROVIDER								
		PROVIDER TO .02								6.02
		PROGRAM								
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)							319,660			7
8 NAME OF CONTRACTOR:							CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [XX] SNF (14-6150)
 BOX: [] IRF [] SWING BED SNF

INPATIENT
 PART A

PART B

DESCRIPTION	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		206,283			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.					
PROGRAM .01		NONE		NONE	3.01
TO .02					3.02
PROVIDER .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					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)		206,283			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 .01					6.01
TO .02					6.02
PROVIDER .01					6.01
PROVIDER .02					6.02
TO .02					6.02
PROGRAM					
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		206,283			7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE:		8

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1343) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	1,179	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,944	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,525	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	74,367,280	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	3,020,666	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	1	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	1	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)		32

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

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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	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	233,635	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)	86,025	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	248	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)	319,660	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	319,660	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	319,660	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	319,660	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)	319,660	19
20 INTERIM PAYMENTS	307,875	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	11,785	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
PERIOD FROM 05/01/2012 TO 04/30/2013

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

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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	3,488,532 1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)	2
3	ORGAN ACQUISITION	3
4	SUBTOTAL (SUM OF LINES 1-3)	3,488,532 4
5	PRIMARY PAYER PAYMENTS	5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	3,523,417 6
COMPUTATION OF LESSER OF COST OR CHARGES		
REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES	7
8	ANCILLARY SERVICE CHARGES	8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	9
10	TOTAL REASONABLE CHARGES	10
CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	12
13	RATIO OF LINE 11 TO LINE 12 (NOT TO EXCEED 1.000000)	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 AND 17)	3,523,417 19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	478,687 20
21	EXCESS REASONABLE COST (FROM LINE 16)	21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	3,044,730 22
23	COINSURANCE	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	3,044,730 24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	80,084 25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	80,084 26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	60,580 27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	3,124,814 28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	3,124,814 30
31	INTERIM PAYMENTS	2,837,232 31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)	32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	287,582 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 VI

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

PROSPECTIVE PAYMENT AMOUNT			
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	254,579	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (SUM OF LINES 1-3)	254,579	4
COMPUTATION OF NET COST OF COVERED SERVICES			
5	MEDICAL AND OTHER SERVICES		5
6	DEDUCTIBLES	1,089	6
7	COINSURANCE	47,207	7
8	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		9
10	ALLOWABLE REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (SUM OF LINES 4, 5 MINUS 6 & 7 PLUS 10 AND 11) (SEE INSTRUCTIONS)	206,283	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		14
15	SUBTOTAL (LINE 12 MINUS 13 ± LINE 14)	206,283	15
16	INTERIM PAYMENTS	206,283	16
17	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		17
18	BALANCE DUE PROVIDER/PROGRAM (LINE 15 MINUS THE SUM OF LINES 16 AND 17)		18
19	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
 PART VII

CHECK TITLE V HOSPITAL (14-1343) SNF PPS
 APPLICABLE 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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1			1
2			2
3		2,589,200	3
4			4
5		2,589,200	5
6			6
7		2,589,200	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	443,108		8
9	1,624,174	8,855,327	9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21		2,589,200	21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29		2,589,200	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31		2,589,200	31
32			32
33			33
34			34
35			35
36		2,589,200	36
37			37
38		2,589,200	38
39			39
40		2,589,200	40
41		2,589,200	41
42			42
43			43

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	10,069,329			1
2 TEMPORARY INVESTMENTS	891,387			2
3 NOTES RECEIVABLE				3
4 ACCOUNTS RECEIVABLE	9,911,769			4
5 OTHER RECEIVABLES				5
6 ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,900,000			6
7 INVENTORY	672,847			7
8 PREPAID EXPENSES	826,258			8
9 OTHER CURRENT ASSETS	230,873			9
10 DUE FROM OTHER FUNDS				10
11 TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	19,702,463			11
FIXED ASSETS				
12 LAND	190,645			12
13 LAND IMPROVEMENTS	1,485,155			13
14 ACCUMULATED DEPRECIATION	-773,319			14
15 BUILDINGS	45,154,615			15
16 ACCUMULATED DEPRECIATION	-17,104,837			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	10,824,310			23
24 ACCUMULATED DEPRECIATION	-8,667,410			24
25 MINOR EQUIPMENT DEPRECIABLE				25
26 ACCUMULATED DEPRECIATION				26
27 HIT DESIGNATED ASSETS	982,181			27
28 ACCUMULATED DEPRECIATION				28
29 MINOR EQUIPMENT-NONDEPRECIABLE				29
30 TOTAL FIXED ASSETS (SUM OF LINES 12-29)	32,091,340			30
OTHER ASSETS				
31 INVESTMENTS	9,980,724			31
32 DEPOSITS ON LEASES				32
33 DUE FROM OWNERS/OFFICERS				33
34 OTHER ASSETS	314,748			34
35 TOTAL OTHER ASSETS (SUM OF LINES 31-34)	10,295,472			35
36 TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	62,089,275			36
LIABILITIES AND FUND BALANCES				
	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
	1	2	3	4
CURRENT LIABILITIES				
37 ACCOUNTS PAYABLE	916,363			37
38 SALARIES, WAGES & FEES PAYABLE	2,490,710			38
39 PAYROLL TAXES PAYABLE				39
40 NOTES & LOANS PAYABLE (SHORT TERM)	844,742			40
41 DEFERRED INCOME	185,969			41
42 ACCELERATED PAYMENTS				42
43 DUE TO OTHER FUNDS				43
44 OTHER CURRENT LIABILITIES	2,207,431			44
45 TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	6,645,215			45
LONG-TERM LIABILITIES				
46 MORTGAGE PAYABLE				46
47 NOTES PAYABLE	15,564,558			47
48 UNSECURED LOANS				48
49 OTHER LONG TERM LIABILITIES	271,158			49
50 TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	15,835,716			50
51 TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	22,480,931			51
CAPITAL ACCOUNTS				
52 GENERAL FUND BALANCE	39,608,344			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)	39,608,344			59
60 TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	62,089,275			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		35,725,069							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		3,883,275							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		39,608,344							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)		39,608,344							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)		39,608,344							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	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	3,056,165		3,056,165	2
3 SUBPROVIDER IPF				3
5 SWING BED - SNF	109,001		109,001	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY	1,186,811		1,186,811	7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	4,351,977		4,351,977	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT				12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)				17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	4,351,977		4,351,977	18
19 ANCILLARY SERVICES	11,505,394	46,258,253	57,763,647	19
20 OUTPATIENT SERVICES		14,111,071	14,111,071	20
20.01 RHC II		5,788,779	5,788,779	20.01
20.02 RHC III		594,451	594,451	20.02
21 RHC		503,431	503,431	21
22 FOHC				22
23 HOME HEALTH AGENCY		835,488	835,488	23
24 AMBULANCE				24
25 ASC				25
26 HOSPICE				26
27 PHYSICIAN PRIVATE OFFICE		567,025	567,025	27
28 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	15,857,371	68,658,498	84,515,869	28

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		40,093,552	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)		40,093,552	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	84,515,869	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	43,242,980	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	41,272,889	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	40,093,552	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	1,179,337	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	106,704	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	164,186	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	24,668	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	109,342	22
23	GOVERNMENTAL APPROPRIATIONS	508,259	23
24	OTHER (CONSULTING CLINIC)	65,388	24
24.01	OTHER (WELLNESS)	89,595	24.01
24.02	OTHER (GRANTS)	39,625	24.02
24.03	OTHER (OTHER PROFESSIONAL INCOME)	832,958	24.03
24.04	OTHER (FOUNDATION REIMBURSEMENT)	13,211	24.04
24.05	OTHER (DONATIONS)	36,764	24.05
24.06	OTHER (OTHER INCOME)	713,238	24.06
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	2,703,938	25
26	TOTAL (LINE 5 PLUS LINE 25)	3,883,275	26
27			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)	3,883,275	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
1 GENERAL SERVICE COST CENTER						1
2 CAPITAL RELATED-BLDGS & FIXTURES						2
3 CAPITAL RELATED-MOVABLE EQUIPMENT						3
4 PLANT OPERATION & MAINTENANCE						4
5 TRANSPORTATION (SEE INSTRUCTIONS)						5
6 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES	101,233	6,580	3,577	25,326	44,312	181,028
7 SKILLED NURSING CARE	258,471	16,801	18,638			293,910
8 PHYSICAL THERAPY	17,308	1,125	4,682	16,634		39,749
9 OCCUPATIONAL THERAPY	8,889	578	1,288			10,755
10 SPEECH PATHOLOGY	1,514		391			1,905
11 MEDICAL SOCIAL SERVICES						10
12 HOME HEALTH AIDE	55,250	3,591	10,365			69,206
13 SUPPLIES (SEE INSTRUCTIONS)						11
14 DRUGS						12
15 DME						13
16 HHA NONREIMBURSABLE SERVICES						14
17 HOME DIALYSIS AIDE SERVICES						15
18 RESPIRATORY THERAPY						16
19 PRIVATE DUTY NURSING						17
20 CLINIC						18
21 HEALTH PROMOTION ACTIVITIES						19
22 DAY CARE PROGRAM						20
23 HOME DELIVERED MEALS PROGRAM						21
24 HOMEMAKER SERVICE						22
25 ALL OTHERS						23
26 TOTAL (SUM OF LINES 1-23)	442,665	28,675	38,941	41,960	44,312	596,553

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- ATTION	SUBTOTAL (COLS.0-4) 4A	ADMIN & GENERAL 5	TOTAL (COLS.4A+5) 6	
	0	1	2	3	4	4A	5	6	
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 & FIXT									
CAPITAL RELATED-MOVABLE EQUIP									
PLANT OPERATION & MAINTENANCE									
TRANSPORTATION (SEE INSTR.)									
ADMINISTRATIVE AND GENERAL	131,592					131,592	131,592		
HHA REIMBURSABLE SERVICES									
SKILLED NURSING CARE	293,910					293,910	93,078	386,988	
PHYSICAL THERAPY	39,749					39,749	12,588	52,337	
OCCUPATIONAL THERAPY	10,755					10,755	3,406	14,161	
SPEECH PATHOLOGY	1,905					1,905	603	2,508	
MEDICAL SOCIAL SERVICES									
HOME HEALTH AIDE	69,206					69,206	21,917	91,123	
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)	547,117					547,117		547,117	

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)

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COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-1
 PART II

	CAP REL COSTS BLDG & FIXTURES (SQUARE FEET) 1	CAP REL COSTS MVBL EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
1	GENERAL SERVICE COST CENTER						1
2	CAPITAL RELATED-BLDGS & FIXT						2
3	CAPITAL RELATED-MOVABLE EQUIP						3
4	PLANT OPERATION & MAINTENANCE						4
5	TRANSPORTATION (SEE INSTR.)						5
6	ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES				-131,592	415,525	6
7	SKILLED NURSING CARE					293,910	7
8	PHYSICAL THERAPY					39,749	8
9	OCCUPATIONAL THERAPY					10,755	9
10	SPEECH PATHOLOGY					1,905	10
11	MEDICAL SOCIAL SERVICES						11
12	HOME HEALTH AIDE					69,206	12
13	SUPPLIES (SEE INSTRUCTIONS)						13
14	DRUGS						14
15	DME						15
16	HHA NONREIMBURSABLE SERVICES						16
17	HOME DIALYSIS AIDE SERVICES						17
18	RESPIRATORY THERAPY						18
19	PRIVATE DUTY NURSING						19
20	CLINIC						20
21	HEALTH PROMOTION ACTIVITIES						21
22	DAY CARE PROGRAM						22
23	HOME DELIVERED MEALS PROGRAM						23
24	HOMEMAKER SERVICE						24
25	ALL OTHERS						25
26	TELEMEDICINE						26
23.50	TOTAL (SUM OF LINES 1-23)				-131,592	415,525	23.50
24	COST TO BE ALLOC (PER W/S H)					131,592	24
25	UNIT COST MULTIPLIER					0.316689	25
26							26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	HHA TRIAL BALANCE 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	OTHER CAP REL COSTS 3	EMPLOYEE BENEFITS 4	NONPATIENT TELEPHONE S 5.01	DATA PROCE SSING 5.02	PURCHASING RECEIVING AND STORE 5.03	
1 ADMINISTRATIVE AND GENERAL			5,499		19,323	897		2,141	1
2 SKILLED NURSING CARE	386,988				49,335				2
3 PHYSICAL THERAPY	52,337				3,304				3
4 OCCUPATIONAL THERAPY	14,161				1,697				4
5 SPEECH PATHOLOGY	2,508				289				5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE	91,123				10,546				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)	547,117		5,499		84,494	897		2,141	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.									21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	ADMITTING 5.04	CASHIERING /ACCOUNTS RECEIVABLE 5.05	SUBTOTAL (COLS.0-4) 4A	OTHER ADMI NISTRATIVE AND GENER 5.06	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE- KEEPING 9	DIETARY 10
1 ADMINISTRATIVE AND GENERAL		16,316	44,176	3,994			2,455	1
2 SKILLED NURSING CARE			436,323	39,443				2
3 PHYSICAL THERAPY			55,641	5,030				3
4 OCCUPATIONAL THERAPY			15,858	1,434				4
5 SPEECH PATHOLOGY			2,797	253				5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE			101,669	9,191				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)		16,316	656,464	59,345			2,455	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.								21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	CAFETERIA 11	NURSING ADMINIS- TRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL (SUM OF COL. 4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25
1 ADMINISTRATIVE AND GENERAL	16,641	73,826					141,092	1
2 SKILLED NURSING CARE							475,766	2
3 PHYSICAL THERAPY							60,671	3
4 OCCUPATIONAL THERAPY							17,292	4
5 SPEECH PATHOLOGY							3,050	5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE							110,860	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)	16,641	73,826					808,731	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.								21

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO. : 14-7175

WORKSHEET H-2
 PART I

HHA COST CENTER	SUBTOTAL (SUM OF COL. 4A-23) 26	ALLOCATED HHA A&G (SEE PT.2) 27	TOTAL HHA COSTS 28	
1 ADMINISTRATIVE AND GENERAL	141,092			1
2 SKILLED NURSING CARE	475,766	100,543	576,309	2
3 PHYSICAL THERAPY	60,671	12,822	73,493	3
4 OCCUPATIONAL THERAPY	17,292	3,654	20,946	4
5 SPEECH PATHOLOGY	3,050	645	3,695	5
6 MEDICAL SOCIAL SERVICES				6
7 HOME HEALTH AIDE	110,860	23,428	134,288	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)	808,731	141,092	808,731	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.		0.211330		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 PROCESsing 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		8,214		101,233	9		8	1
2 SKILLED NURSING CARE				258,471				2
3 PHYSICAL THERAPY				17,308				3
4 OCCUPATIONAL THERAPY				8,889				4
5 SPEECH PATHOLOGY				1,514				5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE				55,250				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)		8,214		442,665	9		8	20
21 TOTAL COST TO BE ALLOCATED		5,499		84,494	897		2,141	21
22 UNIT COST MULTIPLIER					99.666667		267.625000	22
22 UNIT COST MULTIPLIER		0.669467		0.190876				22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA NO.: 14-7175

WORKSHEET H-2
 PART II

HHA COST CENTER	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION 4A.06	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S
	5.05		5.06	7	8	9	10	11
1 ADMINISTRATIVE AND GENERAL	835,489		44,176			450		9
2 SKILLED NURSING CARE			436,323					2
3 PHYSICAL THERAPY			55,641					3
4 OCCUPATIONAL THERAPY			15,858					4
5 SPEECH PATHOLOGY			2,797					5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE			101,669					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)	835,489		656,464			450		9
21 TOTAL COST TO BE ALLOCATED	16,316		59,345			2,455		16,641
22 UNIT COST MULTIPLIER	0.019529		0.090401					22
22 UNIT COST MULTIPLIER						5.455556		1,849.000000

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS
 STATISTICAL BASIS

HHA No. : 14-7175

WORKSHEET H-2
 PART II

HHA COST CENTER	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	
1 ADMINISTRATIVE AND GENERAL	17,813					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)	17,813					20
21 TOTAL COST TO BE ALLOCATED	73,826					21
22 UNIT COST MULTIPLIER	4.144501					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 [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
		WKST H-2,	COSTS	ANCILLARY	COSTS	VISITS	COST PER	
PATIENT SERVICES		PART I,	(FROM	COSTS	(FROM		(COL.3 +	
		COL 28,	WKST H-2,	(FROM	COSTS		COL.4)	
		LINE	PART I)	PART II)	COLS. 1+2)			
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	576,309		576,309	2,757	209.03	1
2	PHYSICAL THERAPY	3	73,493		73,493	867	84.77	2
3	OCCUPATIONAL THERAPY	4	20,946		20,946	232	90.28	3
4	SPEECH PATHOLOGY	5	3,695		3,695	81	45.62	4
5	MEDICAL SOCIAL SERVICES	6						5
6	HOME HEALTH AIDE	7	134,288		134,288	665	201.94	6
7	TOTAL (SUM OF LINES 1-6)		808,731		808,731	4,602		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		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	RATIO	
COST COMPUTATIONS		WKST H-2,	COSTS	ANCILLARY	COSTS	CHARGES	(COL.3 +	
OTHER PATIENT SERVICES		PART I,	(FROM	COSTS	(FROM	(FROM HHA	COL.4)	
		COL 28,	WKST H-2,	(FROM	COSTS	RECORD)		
		LINE	PART I)	PART II)	COLS. 1+2)			
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8		23,883	23,883	36,276	0.658369	15
16	COST OF DRUGS	9						16

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7175

WORKSHEET H-3
 PARTS I & II
 (CONTINUED)

CHECK APPLICABLE BOX: [] TITLE V [XX] 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							
1 SKILLED NURSING CARE	1,203	1,043		251,463	218,018		469,481
2 PHYSICAL THERAPY	497	318		42,131	26,957		69,088
3 OCCUPATIONAL THERAPY	120	82		10,834	7,403		18,237
4 SPEECH PATHOLOGY	56	6		2,555	274		2,829
5 MEDICAL SOCIAL SERVICES							
6 HOME HEALTH AIDE	299	359		60,380	72,496		132,876
7 TOTAL (SUM OF LINES 1-6)	2,175	1,808		367,363	325,148		692,511

PATIENT SERVICES	CBSA NO.	PROGRAM VISITS		TOTAL
		PART A	SUBJECT TO DEDUCTIBLES & COINSUR	
8 SKILLED NURSING CARE	99914	1,203	1,043	8
9 PHYSICAL THERAPY	99914	497	318	9
10 OCCUPATIONAL THERAPY	99914	120	82	10
11 SPEECH PATHOLOGY	99914	56	6	11
12 MEDICAL SOCIAL SERVICES	99914			12
13 HOME HEALTH AIDE	99914	299	359	13
14 TOTAL (SUM OF LINES 8-13)		2,175	1,808	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							
15 COST OF MEDICAL SUPPLIES							15
16 COST OF DRUGS							16

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

LINE	FROM WKST C, PART I, COL. 9,	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	0.606428			COL 2, LINE 2	1
2	OCCUPATIONAL THERAPY				COL 2, LINE 3	2
3	SPEECH PATHOLOGY				COL 2, LINE 4	3
4	MEDICAL SUPPLIES CHRGD TO PAT	0.658372	36,276	23,883	COL 2, LINE 15	4
5	DRUGS CHARGED TO PATIENTS	0.458371			COL 2, LINE 16	5

CALCULATION OF HHA REMIBURSEMENT SETTLEMENT

HHA No.: 14-7175

WORKSHEET H-4
 PARTS I & II

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

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

----- PART B -----

NOT SUBJECT TO DEDUCTIBLES & COINSURANCE SUBJECT TO DEDUCTIBLES & COINSURANCE

PART A
 1

2

3

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

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST (SEE INSTRUCTIONS)			10
11 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	289,455	217,628	11
12 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	2,307	4,754	12
13 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	3,877	2,827	13
14 TOTAL PPS REIMBURSEMENT - PEP EPISODES		4,477	14
15 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	965	2,651	15
16 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17 TOTAL OTHER PAYMENTS			17
18 DME PAYMENTS			18
19 OXYGEN PAYMENTS			19
20 PROSTHETIC AND ORTHOTIC PAYMENTS			20
21 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)			21
22 SUBTOTAL (SUM OF LINES 10-20 MINUS LINE 21)	296,604	232,337	22
23 EXCESS REASONABLE COST (FROM LINE 8)			23
24 SUBTOTAL (LINE 22 MINUS LINE 23)	296,604	232,337	24
25 COINSURANCE BILLED TO PROGRAM PATIENTS (FROM YOUR RECORDS)			25
26 NET COST (LINE 24 MINUS LINE 25)	296,604	232,337	26
27 REIMBURSABLE BAD DEBTS (FROM YOUR RECORDS)			27
28 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)			28
29 TOTAL COSTS - CURRENT COST REPORTING PERIOD (LINE 26 PLUS LINE 27)	296,604	232,337	29
30 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			30
31 SUBTOTAL (LINE 29 PLUS/MINUS LINE 30)	296,604	232,337	31
32 INTERIM PAYMENTS (SEE INSTRUCTIONS)	296,604	232,337	32
33 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			33
34 BALANCE DUE PROVIDER/PROGRAM (LINE 31 MINUS LINES 32 AND 33)			34
35 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		296,604		232,337	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	NONE		NONE	3.01
	.02				3.02
	PROGRAM .03				3.03
	TO .04				3.04
	PROVIDER .05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.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				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 H-4, PART II, COLUMN AS APPROPRIATE, LINE 32)		296,604		232,337	4
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.	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 (SEE INSTR.)	PROGRAM TO .01				6.01
	PROVIDER TO .02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		296,604		232,337	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

CALCULATION OF CAPITAL PAYMENT

WORKSHEET L

CHECK [] TITLE V [XX] HOSPITAL ((14-134) [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)	8
9	(SEE INSTRUCTIONS)	9
10	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS REPORTED ON WORKSHEET S-3, PART I (SEE INSTRUCTIONS)	10
11	SUM OF LINES 7 AND 8	11
12	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (SEE INSTRUCTIONS)	12
	DISPROPORTIONATE SHARE ADJUSTMENT (LINE 10 TIMES LINE 1)	
	TOTAL PROSPECTIVE CAPITAL PAYMENTS (SUM OF LINES 1-2, 6 AND 11)	

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	SUBTOTAL (COLS.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26
GENERAL SERVICE COST CENTERS					
1					1
2					2
4					4
5.01					5.01
5.02					5.02
5.03					5.03
5.04					5.04
5.05					5.05
5.06					5.06
7					7
8					8
9					9
10					10
11					11
13					13
14					14
15					15
16					16
17					17
INPATIENT ROUTINE SERV COST CENTERS					
30					30
43					43
44					44
ANCILLARY SERVICE COST CENTERS					
50					50
52					52
53					53
54					54
54.01					54.01
60					60
62					62
65					65
66					66
69					69
71					71
72					72
73					73
76					76
88					88
88.01					88.01
88.02					88.02
OUTPATIENT SERVICE COST CENTERS					
90					90
91					91
92					92
OTHER REIMBURSABLE COST CENTERS					
101					101
SPECIAL PURPOSE COST CENTERS					
113					113
118					118
NONREIMBURSABLE COST CENTERS					
190					190
192					192
194					194
194.01					194.01
194.02					194.02
194.03					194.03
194.04					194.04
200					200
201					201
202					202
TOTAL (SUM OF LINE 118 AND LINES 190-201)					
203					203
204					204
204					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	2,154,071	2,154,071		2,154,071	-254,030	1,900,041	1
2	PHYSICIAN ASSISTANT							2
3	NURSE PRACTITIONER	74,068	74,068		74,068		74,068	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	562,940	197,172	760,112	-49,833	710,279	-190,965	519,314
10	SUBTOTAL (SUM OF LINES 1-9)	2,791,079	197,172	2,988,251	-49,833	2,938,418	-444,995	2,493,423
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		65,707	65,707		65,707	65,707	15
16	TRANSPORTATION (HEALTH CARE STAFF)							16
17	DEPRECIATION-MEDICAL EQUIPMENT				183,713	183,713	183,713	17
18	PROFESSIONAL LIABILITY INSURANCE		170,784	170,784		170,784	170,784	18
19	OTHER HEALTH CARE COSTS							19
20	ALLOWABLE GME COSTS							20
21	SUBTOTAL (SUM OF LINES 15-20)		236,491	236,491	183,713	420,204	420,204	21
22	TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	2,791,079	433,663	3,224,742	133,880	3,358,622	-444,995	2,913,627
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				46,312	46,312	46,312	29
30	ADMINISTRATIVE COSTS	682,790		682,790		682,790	682,790	30
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	682,790		682,790	46,312	729,102	729,102	31
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	3,473,869	433,663	3,907,532	180,192	4,087,724	-444,995	3,642,729

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	1	2	3	4	5	1
2	5.42	28,714	4,200	22,764		2
3			2,100			3
4	0.61	2,255	2,100	1,281		4
5	6.03	30,969		24,045	30,969	5
6						6
7						7
8	6.03	30,969			30,969	8
9						9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10					2,913,627	10
11						11
12					2,913,627	12
13					1,000000	13
14					729,102	14
15					1,213,740	15
16					1,942,842	16
17						17
18					1,942,842	18
19					1,942,842	19
20					4,856,469	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)		4,856,469	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)		55,354	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)		4,801,115	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)		30,969	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)			5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)		30,969	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)		155.03	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)	155.03	155.03	155.03 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)		7,889	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	1,223,032		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)		1	12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)		155	13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)		126	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)	1,223,158		16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	1,115,960		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	15,830		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	17,350		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	868,222		16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	885,572		16.05
17	PRIMARY PAYOR PAYMENTS		111	17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		120,530	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		195,945	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)		885,461	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)		36,710	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)		922,171	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		46,193	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		46,193	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)			25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)		968,364	26
27	INTERIM PAYMENTS		860,483	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)			28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)		107,881	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

WORKSHEET M-4

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)	2,493,423	2,493,423	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000343	0.001462	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	855	3,645	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	12,750	15,960	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	13,605	19,605	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	2,913,627	2,913,627	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	1,942,842	1,942,842	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.004669	0.006729	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	9,071	13,073	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	22,676	32,678	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	125	532	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	181.41	61.42	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	93	323	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	16,871	19,839	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)		55,354	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)		36,710	16

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

RHC II
 COMPONENT NO: 14-3486

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	6,000		6,000		6,000		6,000	1
2								2
3	150,194		150,194		150,194		150,194	3
4								4
5								5
6								6
7								7
8								8
9	96,508	16,467	112,975		112,975		112,975	9
10	252,702	16,467	269,169		269,169		269,169	10
COSTS UNDER AGREEMENT								
11								11
12								12
13								13
14								14
OTHER HEALTH CARE COSTS								
15		13,753	13,753		13,753		13,753	15
16								16
17								17
18								18
19		57,700	57,700		57,700		57,700	19
20								20
21		71,453	71,453		71,453		71,453	21
22	252,702	87,920	340,622		340,622		340,622	22
(SUM OF LINES 10, 14, AND 21)								
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29		16,591	16,591	5,372	21,963		21,963	29
30	16,306	33,365	49,671		49,671	-10	49,661	30
31	16,306	49,956	66,262	5,372	71,634	-10	71,624	31
(SUM OF LINES 29 AND 30)								
32	269,008	137,876	406,884	5,372	412,256	-10	412,246	32
(SUM OF LINES 22, 28 AND 31)								

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC II
 COMPONENT NO: 14-3486

WORKSHEET M-2

CHECK APPLICABLE BOX [] 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	0.03		4,200	126	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.67	4,544	2,100	1,407	3
4	SUBTOTAL (SUM OF LINES 1-3)	0.70	4,544		1,533	4,544
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.70	4,544			4,544
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				340,622	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				340,622	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				71,624	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				96,540	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				168,164	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				168,164	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				168,164	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				508,786	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC II
 COMPONENT NO: 14-3486

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)	508,786	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	3,885	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	504,901	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	4,544	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	4,544	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	111.11	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)	111.11	111.11	111.11 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	434	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	48,222	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	48,222	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)	58,154	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)	1,212	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	1,005	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	30,340	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	31,345	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)	9,292	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	9,530	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	31,345	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	1,651	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	32,996	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	3,606	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	3,606	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	36,602	26
27	INTERIM PAYMENTS	30,564	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	6,038	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 II
 COMPONENT NO: 14-3486

WORKSHEET M-4

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)	269,169	269,169	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000021	0.001460	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	6	393	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	102	2,100	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	108	2,493	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	340,622	340,622	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	168,164	168,164	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.000317	0.007319	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	53	1,231	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	161	3,724	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	1	70	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	161.00	53.20	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	1	28	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	161	1,490	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)		3,885	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)		1,651	16

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

RHC III
 COMPONENT NO: 14-3488

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	114,819		114,819		114,819	-12,073	102,746	1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	35,967		35,967		35,967		35,967	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	108,987	17,245	126,232	25,627	151,859		151,859	9
10 SUBTOTAL (SUM OF LINES 1-9)	259,773	17,245	277,018	25,627	302,645	-12,073	290,572	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		12,693	12,693		12,693		12,693	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS		15,269	15,269		15,269		15,269	19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		27,962	27,962		27,962		27,962	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	259,773	45,207	304,980	25,627	330,607	-12,073	318,534	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		19,232	19,232		19,232		19,232	29
30 ADMINISTRATIVE COSTS	30,067	10,817	40,884		40,884		40,884	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	30,067	30,049	60,116		60,116		60,116	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	289,840	75,256	365,096	25,627	390,723	-12,073	378,650	32

PROVIDER CCN: 14-1343 CRAWFORD MEMORIAL HOSPITAL
 PERIOD FROM 05/01/2012 TO 04/30/2013

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

VERSION: 2012.11
 09/23/2013 08:40

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC III
 COMPONENT NO: 14-3488

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	0.42	2,160	4,200	1,764	1
2	PHYSICIAN ASSISTANTS			2,100		2
3	NURSE PRACTITIONERS	0.39	1,587	2,100	819	3
4	SUBTOTAL (SUM OF LINES 1-3)	0.81	3,747		2,583	3,747
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	0.81	3,747			3,747
9	PHYSICIAN SERVICES UNDER AGREEMENTS					9
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				318,534	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				318,534	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				60,116	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				97,571	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				157,687	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				157,687	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				157,687	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				476,221	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

RHC III
 COMPONENT NO: 14-3488

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)	476,221	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	2,250	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	473,971	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	3,747	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)		5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	3,747	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	126.49	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)	126.49	126.49	126.49	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	267	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	33,773	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	33,773	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	34,026	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS) (FROM PROVIDER'S RECORDS)	1,227	16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)	1,218	16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	22,543	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	23,761	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	4,376	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	5,693	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	23,761	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	814	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	24,575	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	781	23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	781	24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	25,356	26
27	INTERIM PAYMENTS	18,979	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	6,377	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 III
 COMPONENT NO: 14-3488

WORKSHEET M-4

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)	290,572	290,572	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000242	0.000622	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	70	181	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	714	540	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	784	721	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	318,534	318,534	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	157,687	157,687	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.002461	0.002263	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	388	357	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,172	1,078	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	7	18	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	167.43	59.89	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	2	8	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	335	479	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)		2,250	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)		814	16

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

RHC III
 COMPONENT NO: 14-3488

WORKSHEET M-5

CHECK APPLICABLE BOX [XX] RHC [] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		18,056	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	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 10/18/2012	923	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	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	923	3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		923	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		18,979	4
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.	PROGRAM .01	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	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 (SEE INSTR.	PROGRAM TO .01	6,377	6.01
	PROVIDER TO .02		6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		25,356	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR DATE: 8

***** 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	49.17		12.62				61.79 30
43 NURSERY			69.32				69.32 43
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	4.80	21.20	4.34	13.61			43.95 50
52 DELIVERY ROOM & LABOR ROOM			36.72	3.39			40.11 52
54 RADIOLOGY-DIAGNOSTIC	5.08	30.13	1.48	19.89			56.58 54
54.01 RADIOLOGY-ULTRASOUND	8.46	25.80	2.30	22.66			59.22 54.01
60 LABORATORY	6.69	37.98	2.06	13.87			60.60 60
62 WHOLE BLOOD & PACKED RED BLOOD	31.83	24.29					56.12 62
65 RESPIRATORY THERAPY	18.91	26.06	2.70	6.68			54.35 65
66 PHYSICAL THERAPY	4.05	28.25	0.31	11.83			44.44 66
69 ELECTROCARDIOLOGY	16.09	46.47	1.66	25.34			89.56 69
71 MEDICAL SUPPLIES CHRGED TO PATI	28.93	11.14	4.79	9.81			54.67 71
72 IMPL. DEV. CHARGED TO PATIENT	28.97	49.65		3.69			82.31 72
73 DRUGS CHARGED TO PATIENTS	11.83	37.99	1.53	1.64			52.99 73
76 CARDIAC REHAB		14.26		0.52			14.78 76
90 CLINIC	4.53	33.02	0.04	9.29			46.88 90
91 EMERGENCY	0.02	30.45	1.25	23.72			55.44 91
92 OBSERVATION BEDS	0.42	49.08	3.02	12.42			64.94 92
200 TOTAL CHARGES	6.41	27.07	2.36	12.87			48.71 200

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

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 DAYS							
44 SKILLED NURSING FACILITY	11.77						11.77 44
UTILIZATION PERCENTAGES BASED ON CHARGES							
54 RADIOLOGY-DIAGNOSTIC	0.08						0.08 54
54.01 RADIOLOGY-ULTRASOUND	0.16						0.16 54.01
60 LABORATORY	0.22						0.22 60
62 WHOLE BLOOD & PACKED RED BLOOD	1.52						1.52 62
65 RESPIRATORY THERAPY	1.34						1.34 65
66 PHYSICAL THERAPY	6.84						6.84 66
69 ELECTROCARDIOLOGY	0.07						0.07 69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.26						0.26 71
73 DRUGS CHARGED TO PATIENTS	0.53						0.53 73
200 TOTAL CHARGES	0.45						0.45 200

***** 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		0.08					0.08 54
54.01 RADIOLOGY-ULTRASOUND		0.05					0.05 54.01
60 LABORATORY		0.24					0.24 60
65 RESPIRATORY THERAPY		0.87					0.87 65
66 PHYSICAL THERAPY		2.51					2.51 66
69 ELECTROCARDIOLOGY		0.11					0.11 69
71 MEDICAL SUPPLIES CHRGED TO PATI		1.07					1.07 71
73 DRUGS CHARGED TO PATIENTS		0.47					0.47 73
200 TOTAL CHARGES		0.26					0.26 200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,873,380	5.47	-1,873,380	-12.81		1
2	CAP REL COSTS-MVBLE EQUIP	650,601	1.90	-650,601	-4.45		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	2,982,281	8.70	-2,982,281	-20.39		4
5.01	NONPATIENT TELEPHONES	31,273	0.09	-31,273	-0.21		5.01
5.02	DATA PROCESSING	826,914	2.41	-826,914	-5.65		5.02
5.03	PURCHASING RECEIVING AND STORES	178,906	0.52	-178,906	-1.22		5.03
5.04	ADMITTING	318,601	0.93	-318,601	-2.18		5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	607,003	1.77	-607,003	-4.15		5.05
5.06	OTHER ADMINISTRATIVE AND GENERA	2,183,320	6.37	-2,183,320	-14.93		5.06
7	OPERATION OF PLANT	1,476,116	4.31	-1,476,116	-10.09		7
8	LAUNDRY & LINEN SERVICE	138,517	0.40	-138,517	-0.95		8
9	HOUSEKEEPING	441,352	1.29	-441,352	-3.02		9
10	DIETARY	376,755	1.10	-376,755	-2.58		10
11	CAFETERIA	268,222	0.78	-268,222	-1.83		11
13	NURSING ADMINISTRATION	706,596	2.06	-706,596	-4.83		13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY	756,762	2.21	-756,762	-5.17		15
16	MEDICAL RECORDS & LIBRARY	776,101	2.27	-776,101	-5.31		16
17	SOCIAL SERVICE	31,108	0.09	-31,108	-0.21		17
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,888,044	5.51	2,087,577	14.28	3,975,621	11.60
43	NURSERY	60,744	0.18	73,975	0.51	134,719	0.39
44	SKILLED NURSING FACILITY	1,049,988	3.06	1,190,596	8.14	2,240,584	6.54
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	1,291,867	3.77	1,689,929	11.56	2,981,796	8.70
52	DELIVERY ROOM & LABOR ROOM	113,196	0.33	172,705	1.18	285,901	0.83
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	1,377,149	4.02	1,108,822	7.58	2,485,971	7.26
54.01	RADIOLOGY-ULTRASOUND	200,112	0.58	149,483	1.02	349,595	1.02
60	LABORATORY	1,435,414	4.19	1,014,689	6.94	2,450,103	7.15
62	WHOLE BLOOD & PACKED RED BLOOD	93,696	0.27	28,218	0.19	121,914	0.36
65	RESPIRATORY THERAPY	474,107	1.38	345,652	2.36	819,759	2.39
66	PHYSICAL THERAPY	918,676	2.68	838,396	5.73	1,757,072	5.13
69	ELECTROCARDIOLOGY	24,027	0.07	47,527	0.32	71,554	0.21
71	MEDICAL SUPPLIES CHRGD TO PATI	919,583	2.68	312,177	2.13	1,231,760	3.59
72	IMPL. DEV. CHARGED TO PATIENT	455,660	1.33	127,178	0.87	582,838	1.70
73	DRUGS CHARGED TO PATIENTS	1,144,152	3.34	1,522,993	10.41	2,667,145	7.78
76	CARDIAC REHAB	73,707	0.22	173,799	1.19	247,506	0.72
88	RURAL HEALTH CLINIC (RHC)	3,642,729	10.63	1,213,740	8.30	4,856,469	14.17
88.01	RHC II	412,246	1.20	96,540	0.66	508,786	1.48
88.02	RHC III	378,650	1.11	97,571	0.67	476,221	1.39
90	CLINIC	1,417,125	4.14	639,437	4.37	2,056,562	6.00
91	EMERGENCY	1,215,814	3.55	1,106,705	7.57	2,322,519	6.78
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
101	HOME HEALTH AGENCY	547,117	1.60	261,614	1.79	808,731	2.36
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN			32,746	0.22	32,746	0.10
192	PHYSICIANS' PRIVATE OFFICES	253,617	0.74	39,516	0.27	293,133	0.86
194	NONREIMBURSEABLE						194
194.01	PROFESSIONAL BUILDINGS	87,632	0.26	19,356	0.13	106,988	0.31
194.02	FOUNDATION SERVICES	54,091	0.16	14,810	0.10	68,901	0.20
194.03	WELLNESS	111,228	0.32	132,602	0.91	243,830	0.71
194.04	RENTED SPACE			85,455	0.58	85,455	0.25
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	34,264,179	100.00			34,264,179	100.00

**** 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 OPFS.
(WKST D, PART V, COLUMNS 2, 2.01, 2.02 x COLUMN 1
LESS LINES 61, 66-68, 74, 94, 95 & 96)

2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES
EXCLUDING SERVICES NOT SUBJECT TO OPFS.
(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)

MEDICAID SUPPLEMENTAL & NON-ALLOWABLE SCHEDULE OF EXPENSES 14-3488 14-3486 14-3429 NONE		CLINIC NAME CMH Rural Health Clinic Oblong		REPORTING PERIOD FROM: 5-1-12 TO: 4-30-13		ATTACHMENT #1	
COST CENTER (OMIT CENTS)	COMPENSATION 1	OTHER 2	TOTAL COL.1&2 3	RECLASSIFICATIONS 4	RECLASSIFIED TRIAL BALANCE COL.3&4 5	ADJUSTMENTS INCREASES (DECREASES) 6	NET EXPENSES COL.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	HMWK 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	REPORTING PERIOD	FROM: 5-1-12 TO: 4-30-13	ATTACHMENT #2	
NONE		CMH RHC, Palestine, Oblong	14-3486, 14-3429	14-3488		
	COMPENSATION	OTHER	COL. 1&2	RECLASSIFIED TRIAL BALANCE (COL. 3&4)	ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES (COL. 5&6)
	1	2	3	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		ENCOUNTERS			
DENTAL SERVICES PERSONNEL	FULL TIME PERSONNEL EQUIVALENTS (FTEs)	HEALTH SERVICES HOURS	ENCOUNTERS		
			ON-SITE	OFF-SITE	
	1	2	3	4	5
16	RHC DENTAL STAFF				
17	Dentists				0
18	Dental Hygienist				0
19					0
20					0
21	TOTAL - Dentists(Sum of lines 17 through 20)	0	0	0	0
22	Other - Dental Staff				0
23					0
24					0
25					0
26	SUBTOTAL-Other Dental Staff(Sum of lines 22 through 25)	0	0	0	0
27	TOTAL - Dental Staff(Sum of lines 21 and 26)	0	0	0	0
28	Dental Services Under Agreement				0
29					0
30	TOTAL DENTAL(Sum of lines 27 through 29)	0	0	0	0

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