

CRAWFORD MEMORIAL HOSPITAL

ROBINSON, ILLINOIS

MEDICARE COST ANALYSIS

YEAR ENDED APRIL 30, 2014



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, 2014, 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 18, 2014

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Other Locations

Belleville, IL • Jacksonville, IL • Litchfield, IL • Springfield, 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, 2014, includes two 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 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.

Optimizer Systems, Inc.

WinLASH

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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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. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 09/22/2014	TIME: 13:02
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> 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. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	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 WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY CRAWFORD MEMORIAL HOSPITAL (14-1343) ((PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 05/01/2013 AND ENDING 04/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 09/22/2014 13:02  
spoJ370.r5ZfZsdbalvK5nJkUz8ZG0  
M8IGJ02iCv1Z4pqqWFagWJ3NNv1gio  
EBfz1PJMv00x184

(SIGNED) \_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

PI Encryption: 09/22/2014 13:02  
ve6cloNngcMV4E.Ru3GuZKX0otnwe0  
mmBKC0deHB0gKpenYXC8FXFEhrKMnd  
t9Ma0zNdGu0SeMl0

\_\_\_\_\_  
TITLE  
\_\_\_\_\_  
DATE

PART III - SETTLEMENT SUMMARY

		TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX
		1	2	3	4	5
1	HOSPITAL		103,744	24,109		177,746
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF		20,789			5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY		6,275			7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC			289,095		10
10.01	HEALTH CLINIC - RHC II			11,715		10.01
10.02	HEALTH CLINIC - RHC III			6,974		10.02
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL		130,808	331,893		177,746

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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

Hospital and Hospital Health Care Complex Address:									
1	Street: 1000 NORTH ALLEN STREET				P.O. Box:				1
2	City: ROBINSON		State: IL		ZIP Code: 62454		County: CRAWFORD		2
Hospital and Hospital-Based Component Identification:									
							Payment System (P, T, O, or N)		
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX
	0	1	2	3	4	5	6	7	8
3	Hospital	CRAWFORD MEMORIAL HOSPITAL	14-1343	99914	1	05/01/2005	N	O	P
4	Subprovider - IPF								
5	Subprovider - IRF								
6	Subprovider - (OTHER)								
7	Swing Beds - SNF	CRAWFORD MEMORIAL HOSPITAL	14-Z343	99914		05/01/2005	N	O	N
8	Swing Beds - NF								
9	Hospital-Based SNF	CRAWFORD MEMORIAL HOSPITAL LTC	14-6150	99914		03/29/2012	N	P	N
10	Hospital-Based NF								
11	Hospital-Based OLTC								
12	Hospital-Based HHA	CRAWFORD MEMORIAL HHA	14-7175	99914		08/01/1979	N	P	N
13	Separately Certified ASC								
14	Hospital-Based Hospice								
15	Hospital-Based Health Clinic - RHC	CMH RURAL HEALTH CLINIC	14-3429	99914		11/11/1996	N	O	N
15.01	Hospital-Based Health Clinic - RHC II	PALESTINE RURAL HEALTH CLINIC	14-3486	99914		11/21/2006	N	O	N
15.02	Hospital-Based Health Clinic - RHC III	OBLONG RURAL HEALTH CLINIC	14-3488	99914		05/01/2007	N	O	N
16	Hospital-Based Health Clinic - FQHC								
17	Hospital-Based (CMHC)								
18	Renal Dialysis								
19	Other								
20	Cost Reporting Period (mm/dd/yyyy)		From: 05 / 01 / 2013		To: 04 / 30 / 2014				
21	Type of control (see instructions)		11						
Inpatient PPS Information							1	2	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.						N	N	22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N	22.01
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.						3	N	23
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
			1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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 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.								25
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.				2				26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2				27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.								35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:		36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.								37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:		38
								1	2

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

		V	XVIII	XIX	
<b>Prospective Payment System (PPS)-Capital</b>		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' for no.	N	N	N	48
<b>Teaching Hospitals</b>		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 hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	Y/N	IME	Direct GME	61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1	2	3	4
Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.					
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>					
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
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>					
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

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WORKSHEET S-2  
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings-This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4)	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings-Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	RATIO (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4)	
		1	2	3	4	5	
67							67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86

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WORKSHEET S-2  
PART I

		V	XIX		
<b>Title V and XIX Services</b>		1	2		
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90	
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91	
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92	
93	Does this facility operate an ICF/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	
<b>Rural Providers</b>		1	2		
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106	
107	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 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.	N		107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	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.	Y	N	109	
		Physical	Occupational	Speech	Respiratory
<b>Miscellaneous Cost Reporting Information</b>					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	N		115	
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116	
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N		117	
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118	
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance	
		378,233			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02	
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120	
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121	
<b>Transplant Center Information</b>					
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	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
PART I

All Providers		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141	Name:	Contractor's Name:		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	1	2
156	Subprovider - IPF	N	Y	3
157	Subprovider - IRF	N	N	N
158	Surpvodier - Other			
159	SNF	N	N	
160	HFHA	N	N	
161	CMHC		N	
161.10	CORF			
Multicampus				
165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N		165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5.			166
	Name	County	State	ZIP Code
	0	1	2	3
				CBSA
				FTE/Campus
				4
				5
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act				
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1		168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	05/01/2013	04/30/2014	170

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
<b>PROVIDER ORGANIZATION AND OPERATION</b>					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (see instructions)	N			1
		Y/N	DATE	V/I	
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 'T' FOR INVOLUNTARY.	N			2
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (e.g., chain home offices, drug or medical supply companies) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (see instructions)	N			3
<b>FINANCIAL DATA AND REPORTS</b>					
		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.	Y	A		4
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	N			5
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
		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?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
<b>BAD DEBTS</b>					
			Y/N		
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y		12
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N		13
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N		14
<b>BED COMPLEMENT</b>					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		N		15
<b>PART A</b>					
<b>PART B</b>					
<b>PS&amp;R REPORT DATA</b>					
		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	Y	06/24/2014	Y	06/24/2014
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (see instructions)	N		N	
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

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

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN 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.	N	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	N	33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.	Y	34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	35
HOME OFFICE COSTS		Y/N	DATE
		1	2
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	N	
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
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	
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.	N	
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	
COST REORT PREPARER INFORMATION			
41	FIRST NAME: DAVID	LAST NAME: SCHNAKE	TITLE: PARTNER
42	EMPLOYER: KEB		
43	PHONE NUMBER: 6185291040	E-MAIL ADDRESS: DAVIDS@KEBCPA.COM	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		1	2	3	4	5	6	7	8	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	79,776.00		1,878	411	3,324	1
2	HMO AND OTHER (see instructions)									2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						211		211	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF									6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		25	9,125	79,776.00		2,089	411	3,535	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						207	282	13
14	TOTAL (see instructions)		25	9,125	79,776.00		2,089	618	3,817	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			1,143		7,426	19
20	NURSING FACILITY	45								20
21	OTHER LONG TERM CARE	46								21
22	HOME HEALTH AGENCY	101					4,278		5,063	22
23	ASC (Distinct Part)	115								23
24	HOSPICE (Distinct Part)	116								24
24.10	HOSPICE (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					7,809		29,014	26
26.01	RHC II	88.01					535		4,574	26.01
26.02	RHC III	88.02					236		2,841	26.02
27	TOTAL (sum of lines 14-26)		73							27
28	OBSERVATION BED DAYS							115	555	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)							31	51	32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES				
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
		9	10	11	12	13	14	15	
1	HOSPITAL ADULTS & PEDS. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					480	201	983	1
2	HMO AND OTHER (see instructions)								2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF								5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)								7
8	INTENSIVE CARE UNIT								8
9	CORONARY CARE UNIT								9
10	BURN INTENSIVE CARE UNIT								10
11	SURGICAL INTENSIVE CARE UNIT								11
12	OTHER SPECIAL CARE (SPECIFY)								12
13	NURSERY								13
14	TOTAL (see instructions)		256.19			480	201	983	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF								16
17	SUBPROVIDER - IRF								17
18	SUBPROVIDER I								18
19	SKILLED NURSING FACILITY		19.38						19
20	NURSING FACILITY								20
21	OTHER LONG TERM CARE								21
22	HOME HEALTH AGENCY		8.22						22
23	ASC (Distinct Part)								23
24	HOSPICE (Distinct Part)								24
24.10	HOSPICE (non-distinct part)								24.10
25	CMHC								25
26	RHC		37.35						26
26.01	RHC II		4.29						26.01
26.02	RHC III		3.16						26.02
27	TOTAL (sum of lines 14-26)		328.59						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
<b>SALARIES</b>							
1	200	18,292,842			663,386.00		1
2							2
3							3
4							4
4.01							4.01
5		1,753,700			16,397.00		5
6		754,543			58,326.00		6
7	21						7
7.01							7.01
8							8
9	44	684,368	540				9
10		638,009	-2,534				10
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11							11
12							12
13							13
14							14
15							15
16							16
<b>WAGE-RELATED COSTS</b>							
17							17
18							18
19							19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26		171,097	6,334				26
27		1,444,350	-540				27
28							28
29							29
30		398,000					30
31		89,552					31
32		300,057					32
33							33
34		442,186	-261,538				34
35							35
36			261,538				36
37							37
38		615,540					38
39							39
40		526,528					40
41		616,042					41
42		38,598					42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		15,784,599		15,784,599	588,663.00	26.81	1
2	EXCLUDED AREA SALARIES (see instructions)		1,322,377	-1,994	1,320,383			2
3	SUBTOTAL SALARIES (line 1 minus line 2)		14,462,222	1,994	14,464,216	588,663.00	24.57	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)							4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)							5
6	TOTAL (sum of lines 3 through 5)		14,462,222	1,994	14,464,216	588,663.00	24.57	6
7	TOTAL OVERHEAD COST (see instructions)		4,641,950	5,794	4,647,744			7

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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

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

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL	25
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CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	Supporting Exhibit for Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

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

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

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

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HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

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

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Micro System

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 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		884		16	900	1
2	UNDUPLICATED CENSUS COUNT (see instructions)		157.00		148.00	305.00	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		1.01
5	OTHER ADMINISTRATIVE PERSONNEL		1.00		1.00
6	DIRECT NURSING SERVICE		4.43		4.43
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE		0.15		0.15
9	PHYSICAL THERAPY SUPERVISOR		0.24		0.24
10	OCCUPATIONAL THERAPY SERVICE		0.12		0.12
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE		0.01		0.01
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE				14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE		1.25		1.25
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 (columns 1 through 4)	
		WITHOUT OUTLIERS 1	WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4		
21	SKILLED NURSING VISITS	2,065	310	57	48	2,480	21
22	SKILLED NURSING VISIT CHARGES	382,636	57,574	10,614	8,976	459,800	22
23	PHYSICAL THERAPY VISITS	610	38	5	7	660	23
24	PHYSICAL THERAPY VISIT CHARGES	115,358	7,114	946	1,337	124,755	24
25	OCCUPATIONAL THERAPY VISITS	182	14	4	2	202	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	34,402	2,548	755	382	38,087	26
27	SPEECH PATHOLOGY VISITS	39	13			52	27
28	SPEECH PATHOLOGY VISIT CHARGES	7,323	2,366			9,689	28
29	MEDICAL SOCIAL SERVICE VISITS						29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES						30
31	HOME HEALTH AIDE VISITS	706	133	20	25	884	31
32	HOME HEALTH AIDE VISIT CHARGES	49,109	11,112	88	1,760	62,069	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	3,602	508	86	82	4,278	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	588,828	80,714	12,403	12,455	694,400	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	209		24	5	238	36
37	TOTAL NUMBER OF OUTLIER EPISODES		11			11	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	32,168	4,884	2,146	671	39,869	38

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Micro System

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML	78		78	10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC	68		68	18
19	RHB	61		61	19
20	RHA	24		24	20
21	RMC	155		155	21
22	RMB	161		161	22
23	RMA	372		372	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2	14		14	27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1	14		14	32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	52		52	36
37	LE2	7		7	37
38	LE1	3		3	38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1	4		4	42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1	4		4	46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1	15		15	52
53	CA2				53
54	CA1	41		41	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1	5		5	66
67	BA2				67
68	BA1	14		14	68
69	PE2				69
70	PE1				70

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (sum of col. 2 + 3)	
	1	2	3	4	
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1	1		1	74
75	PB2				75
76	PB1	45		45	76
77	PA2				77
78	PA1	5		5	78
199	AAA				199
200	TOTAL	1,143		1,143	200

SNF SERVICES

		CBSA AT BEGINNING OF COST REPORTING PERIOD	CBSA ON/AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable)	
		1	2	
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (if applicable).	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	684,368	55.11%		202
203	RECRUITMENT				203
204	RETENTION OF EMPLOYEES				204
205	TRAINING	910	0.07%		205
206	OTHER (SPECIFY)				206
207	TOTAL SNF REVENUE (Worksheet G-2, Part I, line 7, column 3)	1,241,901			207

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

COMPONENT CCN: 14-3429

WORKSHEET S-8

CHECK [XX] RHC [ ] FQHC  
APPLICABLE BOX:

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	
		N		10

FACILITY HOURS OF OPERATIONS(1)

	TYPE OPERATION	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
11	CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	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	
		N		12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	1	2	
		N		13
14	PROVIDER NAME: _____ CCN NUMBER: _____			14

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

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

COMPONENT CCN: 14-3486

WORKSHEET S-8

CHECK [XX] RHC [ ] FQHC  
APPLICABLE BOX:

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:

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

10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	1 N	2	10
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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	
11	CLINIC	1	2	3	4	5	6	7	8	9	10	11	12	13	14	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 N	2	12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: _____ CCN NUMBER: _____			14

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

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

COMPONENT CCN: 14-3488

WORKSHEET S-8

CHECK [XX] RHC [ ] FQHC  
APPLICABLE BOX:

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	
		N		10

FACILITY HOURS OF OPERATIONS(1)

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

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

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

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

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.468690	1
---	--	----------	---

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	2,402,618	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID	3,451,890	5
6	MEDICAID CHARGES	13,827,264	6
7	MEDICAID COST (line 1 times line 6)	6,480,700	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	626,192	8

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

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

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

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

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	626,192	19

		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	2,949,035	490,214	3,439,249	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	1,382,183	229,758	1,611,941	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	188,636	31,476	220,112	22
23	COST OF CHARITY CARE (line 21 minus line 22)	1,193,547	198,282	1,391,829	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)	931,020	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	575,885	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	355,135	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	166,448	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	1,558,277	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	2,184,469	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	CAP REL COSTS-BLDG & FIXT		1,994,769	1,994,769	139,767	2,134,536	-100,677	2,033,859	1
2	00200	CAP REL COSTS-MVBLE EQUIP		910,928	910,928	5,272	916,200	-244,857	671,343	2
3	00300	OTHER CAP REL COSTS		27,331	27,331	-27,331			-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	171,097	3,846,779	4,017,876	7,084	4,024,960	-233,186	3,791,774	4
5.01	00540	NONPATIENT TELEPHONES		1,944	1,944	32,159	34,103		34,103	5.01
5.02	00550	DATA PROCESSING	188,689	848,135	1,036,824		1,036,824		1,036,824	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	144,862	38,163	183,025		183,025		183,025	5.03
5.04	00570	ADMITTING	321,040	53,389	374,429	-32,789	341,640		341,640	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	276,081	353,332	629,413		629,413		629,413	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	513,678	2,108,102	2,621,780		2,621,780	-317,738	2,304,042	5.06
7	00700	OPERATION OF PLANT	398,000	1,205,269	1,603,269	34,537	1,637,806	-1,252	1,636,554	7
8	00800	LAUNDRY & LINEN SERVICE	89,552	50,723	140,275		140,275		140,275	8
9	00900	HOUSEKEEPING	300,057	144,313	444,370		444,370		444,370	9
10	01000	DIETARY	442,186	404,128	846,314	-500,566	345,748		345,748	10
11	01100	CAFETERIA				500,566	500,566	-177,438	323,128	11
13	01300	NURSING ADMINISTRATION	615,540	62,162	677,702		677,702		677,702	13
14	01400	CENTRAL SERVICES & SUPPLY								14
15	01500	PHARMACY	526,528	239,347	765,875		765,875	-69,323	696,552	15
16	01600	MEDICAL RECORDS & LIBRARY	616,042	251,598	867,640	4,584	872,224	-2,546	869,678	16
17	01700	SOCIAL SERVICE	38,598	4,045	42,643		42,643		42,643	17
		<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	03000	ADULTS & PEDIATRICS	1,780,516	296,278	2,076,794	-148,408	1,928,386	-16,500	1,911,886	30
43	04300	NURSERY		52	52	48,280	48,332		48,332	43
44	04400	SKILLED NURSING FACILITY	684,368	201,706	886,074	165,995	1,052,069		1,052,069	44
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	OPERATING ROOM	832,447	372,210	1,204,657	775,691	1,980,348	-661,006	1,319,342	50
52	05200	DELIVERY ROOM & LABOR ROOM		551	551	100,128	100,679		100,679	52
53	05300	ANESTHESIOLOGY	617,699	157,992	775,691	-775,691				53
54	05400	RADIOLOGY-DIAGNOSTIC	645,239	720,561	1,365,800	-16,492	1,349,308		1,349,308	54
54.01	05401	RADIOLOGY-ULTRASOUND		194,824	194,824		194,824		194,824	54.01
60	06000	LABORATORY	533,294	1,007,941	1,541,235	-93,469	1,447,766		1,447,766	60
62	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS				93,469	93,469		93,469	62
65	06500	RESPIRATORY THERAPY	350,604	155,883	506,487		506,487	-27,840	478,647	65
66	06600	PHYSICAL THERAPY	675,712	322,538	998,250	-26,793	971,457		971,457	66
69	06900	ELECTROCARDIOLOGY	22,148	1,934	24,082		24,082		24,082	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		691,723	691,723	13,276	704,999		704,999	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS		306,293	306,293		306,293		306,293	72
73	07300	DRUGS CHARGED TO PATIENTS		1,506,851	1,506,851	16,492	1,523,343		1,523,343	73
76	03950	CARDIAC REHAB	7,471	5,941	13,412	17,696	31,108		31,108	76
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	08800	RURAL HEALTH CLINIC	3,579,568	792,726	4,372,294	293,701	4,665,995	-449,357	4,216,638	88
88.01	08801	RHC II	282,417	177,780	460,197	7,636	467,833	-14,436	453,397	88.01
88.02	08802	RHC III	207,182	133,217	340,399	23,362	363,761	-8,332	355,429	88.02
90	09000	CLINIC	2,094,925	1,328,231	3,423,156	-107,035	3,316,121	-1,994,657	1,321,464	90
91	09100	EMERGENCY	699,293	1,479,372	2,178,665		2,178,665	-976,626	1,202,039	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
101	10100	HOME HEALTH AGENCY	437,497	154,468	591,965	-9,734	582,231	-52,107	530,124	101
		<b>SPECIAL PURPOSE COST CENTERS</b>								
113	11300	INTEREST EXPENSE		522,907	522,907	-522,907				113
118		SUBTOTALS (sum of lines 1-117)	18,092,330	23,076,436	41,168,766	18,480	41,187,246	-5,347,878	35,839,368	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES	77,265	184,757	262,022	35,569	297,591		297,591	192
194	07950	NONREIMBURSEABLE								194
194.01	07951	PROFESSIONAL BUILDINGS		122,648	122,648	-48,323	74,325		74,325	194.01
194.02	07952	FOUNDATION SERVICES	24,312	31,625	55,937		55,937		55,937	194.02
194.03	07953	WELLNESS	98,935	11,719	110,654	-5,726	104,928		104,928	194.03
194.04	07954	RENTED SPACE								194.04
200		TOTAL (sum of lines 118-199)	18,292,842	23,427,185	41,720,027		41,720,027	-5,347,878	36,372,149	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	R/C HHA MED SUPPLIES	A	MEDICAL SUPPLIES CHARGED TO P	71		13,276	1
500	TOTAL RECLASSIFICATIONS					13,276	500
	CODE LETTER - A						
1	LTC ADMITTING COSTS	D	SKILLED NURSING FACILITY	44	540	90	1
500	TOTAL RECLASSIFICATIONS				540	90	500
	CODE LETTER - D						
1	R/C CAFETERIA COSTS	F	CAFETERIA	11	261,538	239,028	1
500	TOTAL RECLASSIFICATIONS				261,538	239,028	500
	CODE LETTER - F						
1	R/C COST OF BLOOD	G	WHOLE BLOOD & PACKED RED BLOO	62		93,469	1
500	TOTAL RECLASSIFICATIONS					93,469	500
	CODE LETTER - G						
1	PBX COST	H	NONPATIENT TELEPHONES	5.01	27,431	4,728	1
500	TOTAL RECLASSIFICATIONS				27,431	4,728	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		20,951	1
2			RURAL HEALTH CLINIC	88		183,196	2
3			RHC II	88.01		7,636	3
4			CLINIC	90		23,151	4
5			HOME HEALTH AGENCY	101		3,542	5
6			WELLNESS	194.03		1,358	6
500	TOTAL RECLASSIFICATIONS					239,834	500
	CODE LETTER - J						
1	R/C SNF DEPR	K	SKILLED NURSING FACILITY	44		165,365	1
500	TOTAL RECLASSIFICATIONS					165,365	500
	CODE LETTER - K						
1	R/C LABOR/DEL & NB COSTS	L	NURSERY	43	39,586	8,694	1
2			DELIVERY ROOM & LABOR ROOM	52	82,461	17,667	2
500	TOTAL RECLASSIFICATIONS				122,047	26,361	500
	CODE LETTER - L						
1	R/C TRANSCRIPTION TXFR	N	MEDICAL RECORDS & LIBRARY	16		4,584	1
2							2
500	TOTAL RECLASSIFICATIONS					4,584	500
	CODE LETTER - N						
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	O	DRUGS CHARGED TO PATIENTS	73		16,492	1
500	TOTAL RECLASSIFICATIONS					16,492	500
	CODE LETTER - O						
1	R/C OR COST	O	OPERATING ROOM	50	617,699	157,992	1
500	TOTAL RECLASSIFICATIONS				617,699	157,992	500
	CODE LETTER - Q						
1	R/C PALESTINE/OBLONG DRS	R					1
2			PHYSICIANS' PRIVATE OFFICES	192		31,769	2
3			RHC III	88.02		23,362	3
500	TOTAL RECLASSIFICATIONS					55,131	500
	CODE LETTER - R						
1	HEALTHWORKS COST	U	EMPLOYEE BENEFITS DEPARTMENT	4	6,334	750	1
500	TOTAL RECLASSIFICATIONS				6,334	750	500
	CODE LETTER - U						
1	UTILITIES	V	OPERATION OF PLANT	7		34,537	1
2							2
3							3
500	TOTAL RECLASSIFICATIONS					34,537	500
	CODE LETTER - V						
1	INTEREST EXPENSE	W	CAP REL COSTS-BLDG & FIXT	1		522,907	1
500	TOTAL RECLASSIFICATIONS					522,907	500
	CODE LETTER - W						
1	RHC UTILITIES & MAINTENANCE	X	RURAL HEALTH CLINIC	88		69,274	1

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
500	TOTAL RECLASSIFICATIONS					69,274	500
	CODE LETTER - X						
1	RECLASS RHC & LV SALARY	Y	RURAL HEALTH CLINIC	88	90,117		1
2			PHYSICIANS' PRIVATE OFFICES	192	3,800		2
500	TOTAL RECLASSIFICATIONS				93,917		500
	CODE LETTER - Y						
1	RECLASS CARIDAC REHAB SALARY	Z	CARDIAC REHAB	76	17,696		1
500	TOTAL RECLASSIFICATIONS				17,696		500
	CODE LETTER - Z						
	GRAND TOTAL (INCREASES)				1,147,202	1,643,818	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	R/C HHA MED SUPPLIES	A	HOME HEALTH AGENCY	101		13,276		
500	TOTAL RECLASSIFICATIONS					13,276	1	
	CODE LETTER - A						500	
1	LTC ADMITTING COSTS	D	ADMITTING	5.04	540	90		
500	TOTAL RECLASSIFICATIONS				540	90	1	
	CODE LETTER - D						500	
1	R/C CAFETERIA COSTS	F	DIETARY	10	261,538	239,028		
500	TOTAL RECLASSIFICATIONS				261,538	239,028	1	
	CODE LETTER - F						500	
1	R/C COST OF BLOOD	G	LABORATORY	60		93,469		
500	TOTAL RECLASSIFICATIONS					93,469	1	
	CODE LETTER - G						500	
1	PBX COST	H	ADMITTING	5.04	27,431	4,728		
500	TOTAL RECLASSIFICATIONS				27,431	4,728	1	
	CODE LETTER - H						500	
1	R/C DEPR OBLONG CLINIC	I					9	
500	TOTAL RECLASSIFICATIONS						1	
	CODE LETTER - I						500	
1	R/C DEPR PROF BLDGS	J	CAP REL COSTS-BLDG & FIXT	1		239,834	9	
2							9	
3							9	
4							9	
5							9	
6							9	
500	TOTAL RECLASSIFICATIONS					239,834	6	
	CODE LETTER - J						500	
1	R/C SNF DEPR	K	CAP REL COSTS-BLDG & FIXT	1		165,365	9	
500	TOTAL RECLASSIFICATIONS					165,365	1	
	CODE LETTER - K						500	
1	R/C LABOR/DEL & NB COSTS	L	ADULTS & PEDIATRICS	30	122,047	26,361		
2							2	
500	TOTAL RECLASSIFICATIONS				122,047	26,361	2	
	CODE LETTER - L						500	
1	R/C TRANSCRIPTION TXFR	N	RURAL HEALTH CLINIC	88		1,046		
2			CLINIC	90		3,538		
500	TOTAL RECLASSIFICATIONS					4,584	1	
	CODE LETTER - N						2	
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	O	RADIOLOGY-DIAGNOSTIC	54		16,492		
500	TOTAL RECLASSIFICATIONS					16,492	1	
	CODE LETTER - O						500	
1	R/C OR COST	Q	ANESTHESIOLOGY	53	617,699	157,992		
500	TOTAL RECLASSIFICATIONS				617,699	157,992	1	
	CODE LETTER - Q						500	
1	R/C PALESTINE/OBLONG DRS	R	RURAL HEALTH CLINIC	88		47,840		
2			CLINIC	90		7,291		
3							3	
500	TOTAL RECLASSIFICATIONS					55,131	1	
	CODE LETTER - R						2	
1	HEALTHWORKS COST	U	WELLNESS	194.03	6,334	750		
500	TOTAL RECLASSIFICATIONS				6,334	750	1	
	CODE LETTER - U						500	
1	UTILITIES	V					1	
2			PHYSICAL THERAPY	66		26,793		
3			CLINIC	90		7,744		
500	TOTAL RECLASSIFICATIONS					34,537	2	
	CODE LETTER - V						3	
1	INTEREST EXPENSE	W	INTEREST EXPENSE	113		522,907	11	
500	TOTAL RECLASSIFICATIONS					522,907	1	
	CODE LETTER - W						500	

Optimizer Systems, Inc.

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Micro System

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	RHC UTILITIES & MAINTENANCE	X	PROFESSIONAL BUILDINGS	194.01		69,274	1	
500	TOTAL RECLASSIFICATIONS					69,274	500	
	CODE LETTER - X							
1	RECLASS RHC & LV SALARY	Y	CLINIC	90	93,917		1	
2							2	
500	TOTAL RECLASSIFICATIONS				93,917		500	
	CODE LETTER - Y							
1	RECLASS CARIDAC REHAB SALARY	Z	CLINIC	90	17,696		1	
500	TOTAL RECLASSIFICATIONS				17,696		500	
	CODE LETTER - Z							
	GRAND TOTAL (DECREASES)				1,147,202	1,643,818		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS
			PURCHASES	DONATION	TOTAL			
		1	2	3	4	5	6	7
1	LAND	48,365	192,280		192,280		240,645	1
2	LAND IMPROVEMENTS	1,485,155				174,927	1,310,228	2
3	BUILDINGS AND FIXTURES	39,031,994	15,020,309		15,020,309	7,551,867	46,500,436	3
4	BUILDING IMPROVEMENTS							4
5	FIXED EQUIPMENT							5
6	MOVABLE EQUIPMENT	11,810,457	770,194		770,194	1,097,289	11,483,362	6
7	HIT DESIGNATED ASSETS							7
8	SUBTOTAL (sum of lines 1-7)	52,375,971	15,982,783		15,982,783	8,824,083	59,534,671	8
9	RECONCILING ITEMS							9
10	TOTAL (line 7 minus line 9)	52,375,971	15,982,783		15,982,783	8,824,083	59,534,671	10

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

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(1) (Sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,994,769						1,994,769	1
2	CAP REL COSTS-MVBLE EQUIP	910,928						910,928	2
3	TOTAL (sum of lines 1-2)	2,905,697						2,905,697	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	48,051,309		48,051,309	0.807115			22,059	22,059	1
2	CAP REL COSTS-MVBLE EQU	11,483,362		11,483,362	0.192885			5,272	5,272	2
3	TOTAL (sum of lines 1-2)	59,534,671		59,534,671	1.000000			27,331	27,331	3

	DESCRIPTION	SUMMARY OF CAPITAL							
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)	TOTAL(2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	CAP REL COSTS-BLDG & FIXT	1,589,570	-100,677	522,907			22,059	2,033,859	1
2	CAP REL COSTS-MVBLE EQUIP	666,071					5,272	671,343	2
3	TOTAL (sum of lines 1-2)	2,255,641	-100,677	522,907			27,331	2,705,202	3

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED				
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	A	-100,677	CAP REL COSTS-BLDG & FIXT	1	10
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	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	-1,004,466			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	-177,438	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	-2,546	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND	A	-244,857	CAP REL COSTS-MVBLE EQUIP	2	9
33	PHYS RECRUITING	A	-110,151	OTHER ADMINISTRATIVE AND GENERAL	5.06	33
33.11	EMPLOYEE INJURY	A	-11,121	EMPLOYEE BENEFITS DEPARTMENT	4	33.11
33.22	EMPLOYEE PHYSICALS	A	-438	EMPLOYEE BENEFITS DEPARTMENT	4	33.22
34	ADVERTISING	A	-79,449	OTHER ADMINISTRATIVE AND GENERAL	5.06	34
35	TV ADMINISTRATION	A	-6,508	OTHER ADMINISTRATIVE AND GENERAL	5.06	35
36	TV UTILITIES & REPAIR	A	-1,252	OPERATION OF PLANT	7	36
37						37
38	EMPLOYEE DISCOUNTS	A	-58,232	EMPLOYEE BENEFITS DEPARTMENT	4	38
39	OTHER A & G	A	-57,227	OTHER ADMINISTRATIVE AND GENERAL	5.06	39
40	EMPLOYEE SALES - PHARMACY	B	-17,844	PHARMACY	15	40
41						41
42	CONSULTING CLINIC	B	-82,319	CLINIC	90	42
42.11	OTHER INCOME ROBINSON RHC	B	-191,868	RURAL HEALTH CLINIC	88	42.11
42.22	OTHER INCOME PALESTINE RHC	B	-14,119	RHC II	88.01	42.22
43	340B REVENUE	B	-51,479	PHARMACY	15	43
44	PHYSICIAN EXPENSES	A	-1,160,575	CLINIC	90	44
45	PHYSICIAN EXPENSES	A	-119,678	EMPLOYEE BENEFITS DEPARTMENT	4	45
46	PHYSICIAN EXPENSES	A	-257,489	RURAL HEALTH CLINIC	88	46
47	PHYSICIAN EXPENSES	A	-317	RHC II	88.01	47
48	PHYSICIAN EXPENSES	A	-8,332	RHC III	88.02	48
49						49
49.01	NONALLOW CARELINK COST	A	-52,107	HOME HEALTH AGENCY	101	49.01
49.02	MISC INCOME	B	-26,464	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.02
49.03	AHA & IHA DUES	A	-15,084	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.03
49.04	OB LOCUM TENUMS	A	-16,500	ADULTS & PEDIATRICS	30	49.04
49.05	NONPATIENT CPR	B	-1,364	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.05
49.07	DONATIONS, PROJECTS	B	-44,858	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.07
49.10	DME	A	-105	CLINIC	90	49.10
49.12	CRNA FEES	A	-97,264	OPERATING ROOM	50	49.12
49.13	ADMIN CLAIMS FEES	A	102,924	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.13
49.15	PHYSICIAN FEES	A	-751,658	CLINIC	90	49.15

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8.

		EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED					
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	WKST A-7 REF.	
		1	2	3	4	5	
49.16	CRNA	A	-563,742	OPERATING ROOM	50		49.16
49.17	CRNA	A	-43,717	EMPLOYEE BENEFITS DEPARTMENT	4		49.17
49.18	NONALLOW ADS	A	-57,289	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.18
49.19	NONALLOW COST	A	-22,268	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.19
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-5,347,878				50

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

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12					5

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADI- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	65	RESPIRATORY THERAPY AGGREGATE	27,840	27,840						1
2	91	EMERGENCY AGGREGATE	1,317,806	976,626	341,180					2
200		TOTAL	1,345,646	1,004,466	341,180					200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	65	RESPIRATORY THERAPY AGGREGATE							27,840	1
2	91	EMERGENCY AGGREGATE							976,626	2
200		TOTAL							1,004,466	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS I-IV

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)					260	3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)					867	5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.60	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		3,260.00				9
10	AHSEA (see instructions)		76.21				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.11	38.11				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					248,445	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					248,445	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					248,445	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)						22
23	TOTAL SALARY EQUIVALENCY (see instructions)					248,445	23

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

STANDARD TRAVEL ALLOWANCE							
24	THERAPISTS (line 3 times column 2, line 11)					9,909	24
25	ASSISTANTS (line 4 times column 3, line 11)						25
26	SUBTOTAL (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,909	26
27	STANDARD TRAVEL EXPENSE (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,456	27
28	TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE (sum of lines 26 and 27)					11,365	28
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
29	THERAPISTS (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	ASSISTANTS (column 3, line 10 times column 3, line 12)						30
31	SUBTOTAL (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	OPTIONAL TRAVEL EXPENSE (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (line 28)					11,365	33
34	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 27 and 31)						34
35	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 31 and 32)						35

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

STANDARD TRAVEL EXPENSE							
36	THERAPISTS (line 5 times column 2, line 11)					33,041	36
37	ASSISTANTS (line 6 times column 3, line 11)						37
38	SUBTOTAL (sum of lines 36 and 37)					33,041	38
39	STANDARD TRAVEL EXPENSE (line 7 times the sum of lines 5 and 6)					4,855	39
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE							
40	THERAPISTS (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	ASSISTANTS (column 3, line 9 times column 3, line 10)						41
42	SUBTOTAL (sum of lines 40 and 41)						42
43	OPTIONAL TRAVEL EXPENSE (line 8 times the sum of columns 1-3, line 13)						43
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES: COMPLETE ONE OF THE FOLLOWING THREE LINES 44, 45, OR 46, AS APPROPRIATE.							
44	STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 38 and 39) (see instructions)					37,896	44
45	OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE (sum of lines 39 and 42) (see instructions)						45
46	OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE (sum of lines 42 and 43) (see instructions)						46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3  
PARTS V-VI

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

## PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	93.00				93.00	47
48	OVERTIME RATE (see instructions)	114.32					48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)	10,632					49
<b>CALCULATION OF LIMIT</b>							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)	100.00				100.00	50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)	2,080.00				2,080.00	51
<b>DETERMINATION OF OVERTIME ALLOWANCE</b>							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)	76.21					52
53	OVERTIME COST LIMITATION (line 51 times line 52)	158,517					53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)	10,632					54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)	7,088					55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	3,544				3,544	56

## PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)	248,445	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)	11,365	58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)	37,896	59
60	OVERTIME ALLOWANCE (from column 5, line 56)	3,544	60
61	EQUIPMENT COST (see instructions)		61
62	SUPPLIES (see instructions)		62
63	TOTAL ALLOWANCE (sum of lines 57-62)	301,250	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)	207,061	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)		65

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A. col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT	2,033,859	2,033,859					1
2	CAP REL COSTS-MVBLE EQUIP	671,343		671,343				2
4	EMPLOYEE BENEFITS DEPARTMENT	3,791,774	16,638	840	3,809,252			4
5.01	NONPATIENT TELEPHONES	34,103			6,480	40,583		5.01
5.02	DATA PROCESSING	1,036,824	15,966	134,637	44,575	304	1,232,306	5.02
5.03	PURCHASING RECEIVING AND STORES	183,025	42,479	2,706	34,221	607		5.03
5.04	ADMITTING	341,640	14,045	1,647	69,233	810		5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	629,413	23,228	4,225	65,219	1,012	776,722	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	2,304,042	172,915	7,107	121,348	1,518	455,584	5.06
7	OPERATION OF PLANT	1,636,554	158,025	25,875	94,021	506		7
8	LAUNDRY & LINEN SERVICE	140,275	48,781	2,223	21,155	101		8
9	HOUSEKEEPING	444,370	15,908	1,584	70,883	101		9
10	DIETARY	345,748	64,363	8,637	42,675	708		10
11	CAFETERIA	323,128	37,772		61,784			11
13	NURSING ADMINISTRATION	677,702	20,308		145,411	607		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	696,552	24,362	67,483	124,383	1,012		15
16	MEDICAL RECORDS & LIBRARY	869,678	59,713	12,897	145,529	1,518		16
17	SOCIAL SERVICE	42,643	961	215	9,118	202		17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	1,911,886	205,057	67,869	391,785	4,554		30
43	NURSERY	48,332	8,012		9,352	202		43
44	SKILLED NURSING FACILITY	1,052,069		5,883	161,798	2,834		44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	1,319,342	378,778	128,608	209,398	2,226		50
52	DELIVERY ROOM & LABOR ROOM	100,679	24,035		19,480			52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	1,349,308	65,266	51,839	152,427	1,518		54
54.01	RADIOLOGY-ULTRASOUND	194,824	9,318	368				54.01
60	LABORATORY	1,447,766	32,815	14,915	125,982	708		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	93,469	2,113					62
65	RESPIRATORY THERAPY	478,647	22,095	16,331	82,824	506		65
66	PHYSICAL THERAPY	971,457	192,569	9,386	159,625	708		66
69	ELECTROCARDIOLOGY	24,082	5,226	878	5,232	202		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	704,999	27,205					71
72	IMPL. DEV. CHARGED TO PATIENTS	306,293	12,066					72
73	DRUGS CHARGED TO PATIENTS	1,523,343						73
76	CARDIAC REHAB	31,108	58,637	3,796	5,945	202		76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	4,216,638		35,997	806,080	6,887		88
88.01	RHC II	453,397		853	66,641	708		88.01
88.02	RHC III	355,429		3,900	46,975	2,631		88.02
90	CLINIC	1,321,464		30,724	194,358	4,959		90
91	EMERGENCY	1,202,039	184,442	23,888	165,196	1,113		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY	530,124		2,312	103,351	911		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	35,839,368	1,943,098	667,623	3,762,484	39,875	1,232,306	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		13,449					190
192	PHYSICIANS' PRIVATE OFFICES	297,591			19,150			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	74,325				506		194.01
194.02	FOUNDATION SERVICES	55,937	961		5,743	101		194.02
194.03	WELLNESS	104,928		3,720	21,875	101		194.03
194.04	RENTED SPACE		76,351					194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	36,372,149	2,033,859	671,343	3,809,252	40,583	1,232,306	202

Optimizer Systems, Inc.

WinLASH

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES	263,038						5.03
5.04	ADMITTING	1,387	428,762					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	277		1,500,096				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	3,607			3,066,121	3,066,121		5.06
7	OPERATION OF PLANT	7,214			1,922,195	176,955	2,099,150	7
8	LAUNDRY & LINEN SERVICE	4,162			216,697	19,949	49,949	8
9	HOUSEKEEPING	8,047			540,893	49,794	16,289	9
10	DIETARY	7,214			469,345	43,207	65,904	10
11	CAFETERIA				422,684	38,912	38,677	11
13	NURSING ADMINISTRATION	277			844,305	77,726	20,794	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	2,497			916,289	84,353	24,945	15
16	MEDICAL RECORDS & LIBRARY	1,110			1,090,445	100,385	61,143	16
17	SOCIAL SERVICE				53,139	4,892	984	17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	7,214	106,646	82,103	2,777,114	255,658	209,968	30
43	NURSERY		9,883	6,544	82,325	7,579	8,204	43
44	SKILLED NURSING FACILITY	4,439			1,227,023	112,959	214,158	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	19,145	64,672	229,557	2,351,726	216,498	387,849	50
52	DELIVERY ROOM & LABOR ROOM		25,296	17,853	187,343	17,247	24,611	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	10,544	29,924	327,936	1,988,762	183,083	66,829	54
54.01	RADIOLOGY-ULTRASOUND		9,507	56,533	270,550	24,907	9,541	54.01
60	LABORATORY	48,002	51,279	312,911	2,034,378	187,283	33,601	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		5,004	6,424	107,010	9,851	2,164	62
65	RESPIRATORY THERAPY	2,497	21,923	40,138	664,961	61,216	22,624	65
66	PHYSICAL THERAPY	2,497	17,623	74,004	1,427,869	131,448	197,181	66
69	ELECTROCARDIOLOGY		2,773	13,607	52,000	4,787	5,351	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	65,485	29,038	39,946	866,673	79,785	27,857	71
72	IMPL. DEV. CHARGED TO PATIENTS	29,134	6,021	9,493	363,007	33,418	12,355	72
73	DRUGS CHARGED TO PATIENTS		42,151	117,005	1,682,499	154,889		73
76	CARDIAC REHAB	277	22	4,065	104,052	9,579	60,041	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	16,925			5,082,527	467,894		88
88.01	RHC II	1,665			523,264	48,171		88.01
88.02	RHC III	1,942			410,877	37,825		88.02
90	CLINIC	10,266	844	38,650	1,601,265	147,411	265,859	90
91	EMERGENCY	4,717	6,156	103,423	1,690,974	155,669	188,859	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY	2,220		19,904	658,822	60,650		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	262,761	428,762	1,500,096	35,697,134	3,003,980	2,015,737	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				13,449	1,238	13,771	190
192	PHYSICIANS' PRIVATE OFFICES				316,741	29,159		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				74,831	6,889		194.01
194.02	FOUNDATION SERVICES	277			63,019	5,801	984	194.02
194.03	WELLNESS				130,624	12,025	68,658	194.03
194.04	RENTED SPACE				76,351	7,029		194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	263,038	428,762	1,500,096	36,372,149	3,066,121	2,099,150	202

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							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	286,595						8
9	HOUSEKEEPING		606,976					9
10	DIETARY	6,123	19,216	603,795				10
11	CAFETERIA		11,277		511,550			11
13	NURSING ADMINISTRATION		6,063		19,426	968,314		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		7,274		15,109	56,373	1,104,343	15
16	MEDICAL RECORDS & LIBRARY		17,828		36,693			16
17	SOCIAL SERVICE		287		2,158	8,908		17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	104,237	61,222	220,305	73,387	294,001		30
43	NURSERY	959	2,392		2,158	9,329		43
44	SKILLED NURSING FACILITY	93,817	62,444	357,276	41,010	167,937		44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	33,632	113,092	9,332	36,693	151,282		50
52	DELIVERY ROOM & LABOR ROOM	2,265	7,176		4,317	19,428		52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	15,032	19,486		25,901			54
54.01	RADIOLOGY-ULTRASOUND		2,782					54.01
60	LABORATORY	76	9,797		23,743			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		631					62
65	RESPIRATORY THERAPY	2,153	6,597		15,109	60,861		65
66	PHYSICAL THERAPY	31	57,494		25,901			66
69	ELECTROCARDIOLOGY		1,560					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		8,122					71
72	IMPL. DEV. CHARGED TO PATIENTS		3,602					72
73	DRUGS CHARGED TO PATIENTS						1,104,343	73
76	CARDIAC REHAB		17,507					76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	1,657	77,708		94,974			88
88.01	RHC II	81						88.01
88.02	RHC III	73						88.02
90	CLINIC	3,766			36,693			90
91	EMERGENCY	20,436	55,068	16,882	32,377	129,040		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY		2,581		17,268	71,155		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	284,338	571,206	603,795	502,917	968,314	1,104,343	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		4,015					190
192	PHYSICIANS' PRIVATE OFFICES							192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		11,449					194.01
194.02	FOUNDATION SERVICES		287		2,158			194.02
194.03	WELLNESS	2,257	20,019		6,475			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)	286,595	606,976	603,795	511,550	968,314	1,104,343	202

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						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	1,306,494					16
17	SOCIAL SERVICE		70,368				17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	74,411	44,332	4,114,635		4,114,635	30
43	NURSERY	5,931		118,877		118,877	43
44	SKILLED NURSING FACILITY		16,185	2,292,809		2,292,809	44
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	208,052		3,508,156		3,508,156	50
52	DELIVERY ROOM & LABOR ROOM	16,180		278,567		278,567	52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	297,212		2,596,305		2,596,305	54
54.01	RADIOLOGY-ULTRASOUND	51,237		359,017		359,017	54.01
60	LABORATORY	283,597		2,572,475		2,572,475	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	5,823		125,479		125,479	62
65	RESPIRATORY THERAPY	36,378		869,899		869,899	65
66	PHYSICAL THERAPY	67,071		1,906,995		1,906,995	66
69	ELECTROCARDIOLOGY	12,332		76,030		76,030	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,204		1,018,641		1,018,641	71
72	IMPL. DEV. CHARGED TO PATIENTS	8,604		420,986		420,986	72
73	DRUGS CHARGED TO PATIENTS	106,044		3,047,775		3,047,775	73
76	CARDIAC REHAB	3,684		194,863		194,863	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC			5,724,760		5,724,760	88
88.01	RHC II			571,516		571,516	88.01
88.02	RHC III			448,775		448,775	88.02
90	CLINIC			2,054,994		2,054,994	90
91	EMERGENCY	93,734	7,740	2,390,779		2,390,779	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	HOME HEALTH AGENCY		2,111	812,587		812,587	101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	1,306,494	70,368	35,504,920		35,504,920	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			32,473		32,473	190
192	PHYSICIANS' PRIVATE OFFICES			345,900		345,900	192
194	NONREIMBURSEABLE						194
194.01	PROFESSIONAL BUILDINGS			93,169		93,169	194.01
194.02	FOUNDATION SERVICES			72,249		72,249	194.02
194.03	WELLNESS			240,058		240,058	194.03
194.04	RENTED SPACE			83,380		83,380	194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	1,306,494	70,368	36,372,149		36,372,149	202

Optimizer Systems, Inc.

WinLASH

Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	
		0	1	2	2A	4	5.01	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		16,638	840	17,478	17,478		4
5.01	NONPATIENT TELEPHONES					30	30	5.01
5.02	DATA PROCESSING		15,966	134,637	150,603	205		5.02
5.03	PURCHASING RECEIVING AND STORES		42,479	2,706	45,185	157		5.03
5.04	ADMITTING		14,045	1,647	15,692	318	1	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		23,228	4,225	27,453	299	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		172,915	7,107	180,022	557	1	5.06
7	OPERATION OF PLANT		158,025	25,875	183,900	431		7
8	LAUNDRY & LINEN SERVICE		48,781	2,223	51,004	97		8
9	HOUSEKEEPING		15,908	1,584	17,492	325		9
10	DIETARY		64,363	8,637	73,000	196	1	10
11	CAFETERIA		37,772		37,772	284		11
13	NURSING ADMINISTRATION		20,308		20,308	667		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		24,362	67,483	91,845	571	1	15
16	MEDICAL RECORDS & LIBRARY		59,713	12,897	72,610	668	1	16
17	SOCIAL SERVICE		961	215	1,176	42		17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	15,497	205,057	67,869	288,423	1,798	3	30
43	NURSERY		8,012		8,012	43		43
44	SKILLED NURSING FACILITY	10,516		5,883	16,399	742	2	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	50,155	378,778	128,608	557,541	961	2	50
52	DELIVERY ROOM & LABOR ROOM		24,035		24,035	89		52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC		65,266	51,839	117,105	699	1	54
54.01	RADIOLOGY-ULTRASOUND		9,318	368	9,686			54.01
60	LABORATORY		32,815	14,915	47,730	578	1	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		2,113		2,113			62
65	RESPIRATORY THERAPY		22,095	16,331	38,426	380		65
66	PHYSICAL THERAPY		192,569	9,386	201,955	732	1	66
69	ELECTROCARDIOLOGY		5,226	878	6,104	24		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		27,205		27,205			71
72	IMPL. DEV. CHARGED TO PATIENTS		12,066		12,066			72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB		58,637	3,796	62,433	27		76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC			35,997	35,997	3,698	5	88
88.01	RHC II			853	853	306	1	88.01
88.02	RHC III	12,600		3,900	16,500	216	2	88.02
90	CLINIC			30,724	30,724	892	4	90
91	EMERGENCY		184,442	23,888	208,330	758	1	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY			2,312	2,312	474	1	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	88,768	1,943,098	667,623	2,699,489	17,264	30	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		13,449		13,449			190
192	PHYSICIANS' PRIVATE OFFICES	1,500			1,500	88		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS							194.01
194.02	FOUNDATION SERVICES		961		961	26		194.02
194.03	WELLNESS			3,720	3,720	100		194.03
194.04	RENTED SPACE		76,351		76,351			194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	90,268	2,033,859	671,343	2,795,470	17,478	30	202

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	DATA PROCE SSING	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING	150,808						5.02
5.03	PURCHASING RECEIVING AND STORES		45,342					5.03
5.04	ADMITTING		239	16,250				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	95,054	48		122,855			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	55,754	622			236,956		5.06
7	OPERATION OF PLANT		1,244			13,676	199,251	7
8	LAUNDRY & LINEN SERVICE		717			1,542	4,741	8
9	HOUSEKEEPING		1,387			3,848	1,546	9
10	DIETARY		1,244			3,339	6,256	10
11	CAFETERIA					3,007	3,671	11
13	NURSING ADMINISTRATION		48			6,007	1,974	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		430			6,519	2,368	15
16	MEDICAL RECORDS & LIBRARY		191			7,759	5,804	16
17	SOCIAL SERVICE					378	93	17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS		1,244	4,039	6,724	19,759	19,930	30
43	NURSERY			375	536	586	779	43
44	SKILLED NURSING FACILITY		765			8,730	20,328	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM		3,300	2,452	18,801	16,733	36,817	50
52	DELIVERY ROOM & LABOR ROOM			959	1,462	1,333	2,336	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC		1,818	1,134	26,854	14,150	6,343	54
54.01	RADIOLOGY-ULTRASOUND			360	4,630	1,925	906	54.01
60	LABORATORY		8,274	1,944	25,628	14,475	3,189	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS			190	526	761	205	62
65	RESPIRATORY THERAPY		430	831	3,287	4,731	2,147	65
66	PHYSICAL THERAPY		430	668	6,061	10,159	18,716	66
69	ELECTROCARDIOLOGY			105	1,114	370	508	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		11,287	1,101	3,272	6,166	2,644	71
72	IMPL. DEV. CHARGED TO PATIENTS		5,022	228	777	2,583	1,173	72
73	DRUGS CHARGED TO PATIENTS			1,598	9,583	11,971		73
76	CARDIAC REHAB		48	1	333	740	5,699	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC		2,918			36,149		88
88.01	RHC II		287			3,723		88.01
88.02	RHC III		335			2,923		88.02
90	CLINIC		1,770	32	3,166	11,393	25,235	90
91	EMERGENCY		813	233	8,471	12,031	17,926	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY		383		1,630	4,688		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	150,808	45,294	16,250	122,855	232,154	191,334	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					96	1,307	190
192	PHYSICIANS' PRIVATE OFFICES					2,254		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS					532		194.01
194.02	FOUNDATION SERVICES		48			448	93	194.02
194.03	WELLNESS					929	6,517	194.03
194.04	RENTED SPACE					543		194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	150,808	45,342	16,250	122,855	236,956	199,251	202

Optimizer Systems, Inc.

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Micro System

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							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	58,101						8
9	HOUSEKEEPING		24,598					9
10	DIETARY	1,241	779	86,056				10
11	CAFETERIA		457		45,191			11
13	NURSING ADMINISTRATION		246		1,716	30,966		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY		295		1,335	1,803	105,167	15
16	MEDICAL RECORDS & LIBRARY		722		3,242			16
17	SOCIAL SERVICE		12		191	285		17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	21,133	2,481	31,399	6,483	9,401		30
43	NURSERY	194	97		191	298		43
44	SKILLED NURSING FACILITY	19,019	2,531	50,921	3,623	5,371		44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	6,818	4,581	1,330	3,242	4,838		50
52	DELIVERY ROOM & LABOR ROOM	459	291		381	621		52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	3,047	790		2,288			54
54.01	RADIOLOGY-ULTRASOUND		113					54.01
60	LABORATORY	15	397		2,097			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS		26					62
65	RESPIRATORY THERAPY	437	267		1,335	1,946		65
66	PHYSICAL THERAPY	6	2,330		2,288			66
69	ELECTROCARDIOLOGY		63					69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		329					71
72	IMPL. DEV. CHARGED TO PATIENTS		146					72
73	DRUGS CHARGED TO PATIENTS						105,167	73
76	CARDIAC REHAB		709					76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	336	3,149		8,389			88
88.01	RHC II	16						88.01
88.02	RHC III	15						88.02
90	CLINIC	764			3,242			90
91	EMERGENCY	4,143	2,232	2,406	2,860	4,127		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY		105		1,525	2,276		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
113	INTEREST EXPENSE							113
118	SUBTOTALS (sum of lines 1-117)	57,643	23,148	86,056	44,428	30,966	105,167	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		163					190
192	PHYSICIANS' PRIVATE OFFICES							192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		464					194.01
194.02	FOUNDATION SERVICES		12		191			194.02
194.03	WELLNESS	458	811		572			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)	58,101	24,598	86,056	45,191	30,966	105,167	202

Optimizer Systems, Inc.

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						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	90,997					16
17	SOCIAL SERVICE		2,177				17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	5,181	1,372	419,370		419,370	30
43	NURSERY	413		11,524		11,524	43
44	SKILLED NURSING FACILITY		501	128,932		128,932	44
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	14,486		671,902		671,902	50
52	DELIVERY ROOM & LABOR ROOM	1,127		33,093		33,093	52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	20,725		194,954		194,954	54
54.01	RADIOLOGY-ULTRASOUND	3,567		21,187		21,187	54.01
60	LABORATORY	19,746		124,074		124,074	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	405		4,226		4,226	62
65	RESPIRATORY THERAPY	2,533		56,750		56,750	65
66	PHYSICAL THERAPY	4,670		248,016		248,016	66
69	ELECTROCARDIOLOGY	859		9,147		9,147	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,521		54,525		54,525	71
72	IMPL. DEV. CHARGED TO PATIENTS	599		22,594		22,594	72
73	DRUGS CHARGED TO PATIENTS	7,383		135,702		135,702	73
76	CARDIAC REHAB	256		70,246		70,246	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC			90,641		90,641	88
88.01	RHC II			5,186		5,186	88.01
88.02	RHC III			19,991		19,991	88.02
90	CLINIC			77,222		77,222	90
91	EMERGENCY	6,526	239	271,096		271,096	91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	HOME HEALTH AGENCY		65	13,459		13,459	101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)	90,997	2,177	2,683,837		2,683,837	118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			15,015		15,015	190
192	PHYSICIANS' PRIVATE OFFICES			3,842		3,842	192
194	NONREIMBURSEABLE						194
194.01	PROFESSIONAL BUILDINGS			996		996	194.01
194.02	FOUNDATION SERVICES			1,779		1,779	194.02
194.03	WELLNESS			13,107		13,107	194.03
194.04	RENTED SPACE			76,894		76,894	194.04
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	90,997	2,177	2,795,470		2,795,470	202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5 01	5 02	5 03	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT	105,860						1
2	CAP REL COSTS-MVBLE EQUIP		910,579					2
4	EMPLOYEE BENEFITS DEPARTMENT	866	1,139	16,124,956				4
5.01	NONPATIENT TELEPHONES			27,431	401			5.01
5.02	DATA PROCESSING	831	182,617	188,689	3	10,000		5.02
5.03	PURCHASING RECEIVING AND STORES	2,211	3,670	144,862	6		948	5.03
5.04	ADMITTING	731	2,234	293,069	8		5	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,209	5,731	276,081	10	6,303	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,000	9,639	513,678	15	3,697	13	5.06
7	OPERATION OF PLANT	8,225	35,096	398,000	5		26	7
8	LAUNDRY & LINEN SERVICE	2,539	3,015	89,552	1		15	8
9	HOUSEKEEPING	828	2,148	300,057	1		29	9
10	DIETARY	3,350	11,715	180,648	7		26	10
11	CAFETERIA	1,966		261,538				11
13	NURSING ADMINISTRATION	1,057		615,540	6		1	13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	1,268	91,531	526,528	10		9	15
16	MEDICAL RECORDS & LIBRARY	3,108	17,493	616,042	15		4	16
17	SOCIAL SERVICE	50	291	38,598	2			17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	10,673	92,055	1,658,469	45		26	30
43	NURSERY	417		39,586	2			43
44	SKILLED NURSING FACILITY		7,980	684,908	28		16	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	19,715	174,438	886,404	22		69	50
52	DELIVERY ROOM & LABOR ROOM	1,251		82,461				52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	3,397	70,312	645,239	15		38	54
54.01	RADIOLOGY-ULTRASOUND	485	499					54.01
60	LABORATORY	1,708	20,230	533,294	7		173	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	110						62
65	RESPIRATORY THERAPY	1,150	22,150	350,604	5		9	65
66	PHYSICAL THERAPY	10,023	12,731	675,712	7		9	66
69	ELECTROCARDIOLOGY	272	1,191	22,148	2			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,416					236	71
72	IMPL. DEV. CHARGED TO PATIENTS	628					105	72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB	3,052	5,149	25,167	2		1	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC		48,825	3,412,196	68		61	88
88.01	RHC II		1,157	282,100	7		6	88.01
88.02	RHC III		5,290	198,850	26		7	88.02
90	CLINIC		41,672	822,737	49		37	90
91	EMERGENCY	9,600	32,400	699,293	11		17	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY		3,136	437,497	9		8	101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	101,136	905,534	15,926,978	394	10,000	947	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	700						190
192	PHYSICIANS' PRIVATE OFFICES			81,065				192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				5			194.01
194.02	FOUNDATION SERVICES	50		24,312	1		1	194.02
194.03	WELLNESS		5,045	92,601	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	2,033,859	671,343	3,809,252	40,583	1,232,306	263,038	202
203	UNIT COST MULT-WS B PT I	19,212,724	0,737,270	0,236,233	101,204,489	123,230,600	277,466,245	203
204	COST TO BE ALLOC PER B PT II			17,478	30	150,808	45,342	204
205	UNIT COST MULT-WS B PT II			0,001,084	0,074,813	15,080,800	47,829,114	205

Optimizer Systems, Inc.

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	5A.06	5.06	7	8	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING	12,860,387						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		67,954,803					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-3,066,121	33,306,028			5.06
7	OPERATION OF PLANT				1,922,195	106,703		7
8	LAUNDRY & LINEN SERVICE				216,697	2,539	195,788	8
9	HOUSEKEEPING				540,893	828		9
10	DIETARY				469,345	3,350	4,183	10
11	CAFETERIA				422,684	1,966		11
13	NURSING ADMINISTRATION				844,305	1,057		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY				916,289	1,268		15
16	MEDICAL RECORDS & LIBRARY				1,090,445	3,108		16
17	SOCIAL SERVICE				53,139	50		17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	3,198,862	3,719,257		2,777,114	10,673	71,210	30
43	NURSERY	296,444	296,444		82,325	417	655	43
44	SKILLED NURSING FACILITY				1,227,023	10,886	64,091	44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	1,939,763	10,398,946		2,351,726	19,715	22,976	50
52	DELIVERY ROOM & LABOR ROOM	758,728	808,729		187,343	1,251	1,547	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	897,532	14,855,906		1,988,762	3,397	10,269	54
54.01	RADIOLOGY-ULTRASOUND	285,152	2,560,942		270,550	485		54.01
60	LABORATORY	1,538,053	14,174,907		2,034,378	1,708	52	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	150,104	291,025		107,010	110		62
65	RESPIRATORY THERAPY	657,556	1,818,272		664,961	1,150	1,471	65
66	PHYSICAL THERAPY	528,598	3,352,381		1,427,869	10,023	21	66
69	ELECTROCARDIOLOGY	83,170	616,383		52,000	272		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	870,953	1,809,545		866,673	1,416		71
72	IMPL. DEV. CHARGED TO PATIENTS	180,583	430,026		363,007	628		72
73	DRUGS CHARGED TO PATIENTS	1,264,277	5,300,335		1,682,499			73
76	CARDIAC REHAB	652	184,123		104,052	3,052		76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC				5,082,527		1,132	88
88.01	RHC II				523,264		55	88.01
88.02	RHC III				410,877		50	88.02
90	CLINIC	25,327	1,750,872		1,601,265	13,514	2,573	90
91	EMERGENCY	184,633	4,685,075		1,690,974	9,600	13,961	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY		901,635		658,822			101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	12,860,387	67,954,803	-3,066,121	32,631,013	102,463	194,246	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				13,449	700		190
192	PHYSICIANS' PRIVATE OFFICES				316,741			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				74,831			194.01
194.02	FOUNDATION SERVICES				63,019	50		194.02
194.03	WELLNESS				130,624	3,490	1,542	194.03
194.04	RENTED SPACE				76,351			194.04
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	428,762	1,500,096		3,066,121	2,099,150	286,595	202
203	UNIT COST MULT-WS B PT I	0.033340	0.022075		0.092059	19.672830	1.463803	203
204	COST TO BE ALLOC PER B PT II	16,250	122,855		236,956	199,251	58,101	204
205	UNIT COST MULT-WS B PT II	0.001264	0.001808		0.007115	1.867342	0.296755	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINISTRATION NURSING HOURS	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							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	105,815						9
10	DIETARY		45,422					10
11	CAFETERIA	1,966			237			11
13	NURSING ADMINISTRATION	1,057			9	232,609		13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	1,268			7	13,542	1,506,851	15
16	MEDICAL RECORDS & LIBRARY	3,108			17		65,302,296	16
17	SOCIAL SERVICE	50			1	2,140		17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	10,673	16,573		34	70,625	3,719,257	30
43	NURSERY	417			1	2,241	296,444	43
44	SKILLED NURSING FACILITY	10,886	26,877		19	40,342		44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	19,715	702		17	36,341	10,398,946	50
52	DELIVERY ROOM & LABOR ROOM	1,251			2	4,667	808,729	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	3,397			12		14,855,906	54
54.01	RADIOLOGY-ULTRASOUND	485					2,560,942	54.01
60	LABORATORY	1,708			11		14,174,907	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	110					291,025	62
65	RESPIRATORY THERAPY	1,150			7	14,620	1,818,272	65
66	PHYSICAL THERAPY	10,023			12		3,352,381	66
69	ELECTROCARDIOLOGY	272					616,383	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,416					1,809,545	71
72	IMPL. DEV. CHARGED TO PATIENTS	628					430,026	72
73	DRUGS CHARGED TO PATIENTS					1,506,851	5,300,355	73
76	CARDIAC REHAB	3,052					184,123	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	13,547			44			88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC				17			90
91	EMERGENCY	9,600	1,270		15	30,998	4,685,075	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY	450			8	17,093		101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	99,579	45,422	233	232,609	1,506,851	65,302,296	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	700						190
192	PHYSICIANS' PRIVATE OFFICES							192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	1,996						194.01
194.02	FOUNDATION SERVICES	50			1			194.02
194.03	WELLNESS	3,490			3			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	606,976	603,795	511,550	968,314	1,104,343	1,306,494	202
203	UNIT COST MULT-WS B PT I	5,736,200	13,293,008	2,158,438,819	4,162,840	0,732,881	0,020,007	203
204	COST TO BE ALLOC PER B PT II	24,598	86,056	45,191	30,966	105,167	90,997	204
205	UNIT COST MULT-WS B PT II	0,232,462	1,894,589	190,679,325	0,133,125	0,069,793	0,001,393	205

Optimizer Systems, Inc.

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Micro System

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME						
		17						

	<b>GENERAL SERVICE COST CENTERS</b>							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							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	100						17
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	63						30
43	NURSERY							43
44	SKILLED NURSING FACILITY	23						44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM							50
52	DELIVERY ROOM & LABOR ROOM							52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	LABORATORY							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS							62
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76	CARDIAC REHAB							76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC							90
91	EMERGENCY	11						91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY	3						101
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	100						118
	<b>NONREIMBURSABLE COST CENTERS</b>							
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	70,368						202
203	UNIT COST MULT-WS B PT I	703.680000						203
204	COST TO BE ALLOC PER B PT II	2,177						204
205	UNIT COST MULT-WS B PT II	21.770000						205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	4,114,635		4,114,635		4,114,635	30
43	NURSERY	118,877		118,877		118,877	43
44	SKILLED NURSING FACILITY	2,292,809		2,292,809		2,292,809	44
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	3,508,156		3,508,156		3,508,156	50
52	DELIVERY ROOM & LABOR ROOM	278,567		278,567		278,567	52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	2,596,305		2,596,305		2,596,305	54
54.01	RADIOLOGY-ULTRASOUND	359,017		359,017		359,017	54.01
60	LABORATORY	2,572,475		2,572,475		2,572,475	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	125,479		125,479		125,479	62
65	RESPIRATORY THERAPY	869,899		869,899		869,899	65
66	PHYSICAL THERAPY	1,906,995		1,906,995		1,906,995	66
69	ELECTROCARDIOLOGY	76,030		76,030		76,030	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,018,641		1,018,641		1,018,641	71
72	IMPL. DEV. CHARGED TO PATIENTS	420,986		420,986		420,986	72
73	DRUGS CHARGED TO PATIENTS	3,047,775		3,047,775		3,047,775	73
76	CARDIAC REHAB	194,863		194,863		194,863	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC	5,724,760		5,724,760		5,724,760	88
88.01	RHC II	571,516		571,516		571,516	88.01
88.02	RHC III	448,775		448,775		448,775	88.02
90	CLINIC	2,054,994		2,054,994		2,054,994	90
91	EMERGENCY	2,390,779		2,390,779		2,390,779	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	558,341		558,341		558,341	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	HOME HEALTH AGENCY	812,587		812,587		812,587	101
113	INTEREST EXPENSE						113
200	SUBTOTAL (SEE INSTRUCTIONS)	36,063,261		36,063,261		36,063,261	200
201	LESS OBSERVATION BEDS	558,341		558,341		558,341	201
202	TOTAL (SEE INSTRUCTIONS)	35,504,920		35,504,920		35,504,920	202

Optimizer Systems, Inc.

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Micro System

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	3,173,862		3,173,862				30
43	NURSERY	296,444		296,444				43
44	SKILLED NURSING FACILITY	1,241,901		1,241,901				44
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	1,939,763	8,459,183	10,398,946	0.337357	0.337357	0.337357	50
52	DELIVERY ROOM & LABOR ROOM	758,728	50,000	808,728	0.344451	0.344451	0.344451	52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	897,532	13,958,374	14,855,906	0.174766	0.174766	0.174766	54
54.01	RADIOLOGY-ULTRASOUND	285,152	2,275,790	2,560,942	0.140189	0.140189	0.140189	54.01
60	LABORATORY	1,538,053	12,636,853	14,174,906	0.181481	0.181481	0.181481	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	150,104	140,921	291,025	0.431162	0.431162	0.431162	62
65	RESPIRATORY THERAPY	657,556	1,160,716	1,818,272	0.478421	0.478421	0.478421	65
66	PHYSICAL THERAPY	528,598	2,823,783	3,352,381	0.568848	0.568848	0.568848	66
69	ELECTROCARDIOLOGY	83,170	533,213	616,383	0.123349	0.123349	0.123349	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	870,953	938,592	1,809,545	0.562927	0.562927	0.562927	71
72	IMPL. DEV. CHARGED TO PATIENTS	180,583	249,443	430,026	0.978978	0.978978	0.978978	72
73	DRUGS CHARGED TO PATIENTS	1,264,277	4,036,059	5,300,336	0.575015	0.575015	0.575015	73
76	CARDIAC REHAB	652	183,471	184,123	1.058331	1.058331	1.058331	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC		5,737,543	5,737,543				88
88.01	RHC II		612,792	612,792				88.01
88.02	RHC III		206,441	206,441				88.02
90	CLINIC	25,327	1,725,545	1,750,872	1.173697	1.173697	1.173697	90
91	EMERGENCY	184,633	4,500,442	4,685,075	0.510297	0.510297	0.510297	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	25,000	520,395	545,395	1.023737	1.023737	1.023737	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
101	HOME HEALTH AGENCY		901,635	901,635				101
113	INTEREST EXPENSE							113
200	SUBTOTAL (SEE INSTRUCTIONS)	14,102,288	61,651,191	75,753,479				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	14,102,288	61,651,191	75,753,479				202

Optimizer Systems, Inc.

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Micro System

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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1343

WORKSHEET D  
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	0.337357		2,226,866			751,249	50
52	DELIVERY ROOM & LABOR ROOM	0.344451						52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	0.174766		4,839,244			845,735	54
54.01	RADIOLOGY-ULTRASOUND	0.140189		705,932			98,964	54.01
60	LABORATORY	0.181481		5,635,870			1,022,803	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.431162		73,914			31,869	62
65	RESPIRATORY THERAPY	0.478421		472,861			226,227	65
66	PHYSICAL THERAPY	0.568848		928,489			528,169	66
69	ELECTROCARDIOLOGY	0.123349		267,345			32,977	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.562927		217,857			122,638	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.978978		132,770			129,979	72
73	DRUGS CHARGED TO PATIENTS	0.575015		2,151,681			1,237,249	73
76	CARDIAC REHAB	1.058331		32,448			34,341	76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	CLINIC	1.173697		553,822			650,019	90
91	EMERGENCY	0.510297		1,354,179			691,033	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.023737		257,656			263,772	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	SUBTOTAL (see instructions)			19,850,934			6,667,024	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)			19,850,934			6,667,024	202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z343

WORKSHEET D  
PART V

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

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	0.337357							50
52	DELIVERY ROOM & LABOR ROOM	0.344451							52
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.174766							54
54.01	RADIOLOGY-ULTRASOUND	0.140189							54.01
60	LABORATORY	0.181481							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.431162							62
65	RESPIRATORY THERAPY	0.478421							65
66	PHYSICAL THERAPY	0.568848							66
69	ELECTROCARDIOLOGY	0.123349							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.562927							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.978978							72
73	DRUGS CHARGED TO PATIENTS	0.575015							73
76	CARDIAC REHAB	1.058331							76
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	1.173697							90
91	EMERGENCY	0.510297							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.023737							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

**WinLASH**

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-6150

WORKSHEET D  
PART IV

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

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)
		1	2	3	4	5	6
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY-ULTRASOUND						54.01
60	LABORATORY						60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS						62
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIAC REHAB						76
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC						88
88.01	RHC II						88.01
88.02	RHC III						88.02
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-6150

WORKSHEET D  
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
		7	8	9	10	11	12	13
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	10,398,946						50
52	DELIVERY ROOM & LABOR ROOM	808,728						52
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	14,855,906			31,143			54
54.01	RADIOLOGY-ULTRASOUND	2,560,942			1,052			54.01
60	LABORATORY	14,174,906			37,316			60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	291,025			5,234			62
65	RESPIRATORY THERAPY	1,818,272			56,669			65
66	PHYSICAL THERAPY	3,352,381			292,750			66
69	ELECTROCARDIOLOGY	616,383			690			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,809,545			5,629			71
72	IMPL. DEV. CHARGED TO PATIENTS	430,026						72
73	DRUGS CHARGED TO PATIENTS	5,300,336			45,461			73
76	CARDIAC REHAB	184,123						76
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
88	RURAL HEALTH CLINIC	5,737,543						88
88.01	RHC II	612,792						88.01
88.02	RHC III	206,441						88.02
90	CLINIC	1,750,872			3,030			90
91	EMERGENCY	4,685,075						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	545,395						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)	70,139,637			478,974			200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-6150

WORKSHEET D  
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	0.337357							50
52	DELIVERY ROOM & LABOR ROOM	0.344451							52
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.174766							54
54.01	RADIOLOGY-ULTRASOUND	0.140189							54.01
60	LABORATORY	0.181481							60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.431162							62
65	RESPIRATORY THERAPY	0.478421							65
66	PHYSICAL THERAPY	0.568848							66
69	ELECTROCARDIOLOGY	0.123349							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.562927							71
72	IMPL. DEV. CHARGED TO PATIENTS	0.978978							72
73	DRUGS CHARGED TO PATIENTS	0.575015							73
76	CARDIAC REHAB	1.058331							76
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	1.173697							90
91	EMERGENCY	0.510297							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.023737							92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	SUBTOTAL (see instructions)								200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)								202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
PART I

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

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	ADULTS & PEDIATRICS (General Routine Care)	419,370	21,635	397,735	3,879	102.54	411	42,144	30
31	INTENSIVE CARE UNIT								31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF								40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	11,524		11,524	282	40.87	207	8,460	43
44	SKILLED NURSING FACILITY	128,932		128,932	7,426	17.36			44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	559,826		538,191	11,587		618	50,604	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1343

WORKSHEET D  
PART II

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
		CAPITAL RELATED COST (from Wkst. B, Part II (col. 26))	TOTAL CHARGES (from Wkst. C, Part I, (col. 8))	RATIO OF COST TO CHARGES (col. 1 + col. 2)	INPATIENT PROGRAM CHARGES	CAPITAL COSTS (col. 3 x col. 4)	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	671,902	10,398,946	0.064613	525,725	33,969	50
52	DELIVERY ROOM & LABOR ROOM	33,093	808,728	0.040920	336,808	13,782	52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	194,954	14,855,906	0.013123	182,702	2,398	54
54.01	RADIOLOGY-ULTRASOUND	21,187	2,560,942	0.008273	34,906	289	54.01
60	LABORATORY	124,074	14,174,906	0.008753	331,170	2,899	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	4,226	291,025	0.014521			62
65	RESPIRATORY THERAPY	56,750	1,818,272	0.031211	53,496	1,670	65
66	PHYSICAL THERAPY	248,016	3,352,381	0.073982	3,260	241	66
69	ELECTROCARDIOLOGY	9,147	616,383	0.014840	4,980	74	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	54,525	1,809,545	0.030132	101,536	3,059	71
72	IMPL. DEV. CHARGED TO PATIENTS	22,594	430,026	0.052541	18,196	956	72
73	DRUGS CHARGED TO PATIENTS	135,702	5,300,336	0.025603	226,334	5,795	73
76	CARDIAC REHAB	70,246	184,123	0.381517			76
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC	90,641	5,737,543	0.015798			88
88.01	RHC II	5,186	612,792	0.008463			88.01
88.02	RHC III	19,991	206,441	0.096836			88.02
90	CLINIC	77,222	1,750,872	0.044105	689	30	90
91	EMERGENCY	271,096	4,685,075	0.057864	79,058	4,575	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	60,003	545,395	0.110018	15,012	1,652	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)	2,170,555	70,139,637		1,913,872	71,389	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

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

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

(A) Worksheet A line numbers

Optimizer Systems, Inc.

*WinLASH*

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
PART III

CHECK  TITLE V  PPS  
 APPLICABLE  TITLE XVIII, PART A  TEFRA  
 BOXES:  TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5+ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	3,879		411		30
31	INTENSIVE CARE UNIT					31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF					40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	282		207		43
44	SKILLED NURSING FACILITY	7,426				44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	11,587		618		200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

**WinLASH**

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1343

WORKSHEET D  
PART IV

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

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6
		NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY-ULTRASOUND						54.01
60	LABORATORY						60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS						62
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIAC REHAB						76
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC						88
88.01	RHC II						88.01
88.02	RHC III						88.02
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1343

WORKSHEET D  
PART IV

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

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	10,398,946			525,725				50
52	DELIVERY ROOM & LABOR ROOM	808,728			336,808				52
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	14,855,906			182,702				54
54.01	RADIOLOGY-ULTRASOUND	2,560,942			34,906				54.01
60	LABORATORY	14,174,906			331,170				60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	291,025							62
65	RESPIRATORY THERAPY	1,818,272			53,496				65
66	PHYSICAL THERAPY	3,352,381			3,260				66
69	ELECTROCARDIOLOGY	616,383			4,980				69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,809,545			101,536				71
72	IMPL. DEV. CHARGED TO PATIENTS	430,026			18,196				72
73	DRUGS CHARGED TO PATIENTS	5,300,336			226,334				73
76	CARDIAC REHAB	184,123							76
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	RURAL HEALTH CLINIC	5,737,543							88
88.01	RHC II	612,792							88.01
88.02	RHC III	206,441							88.02
90	CLINIC	1,750,872			689				90
91	EMERGENCY	4,685,075			79,058				91
92	OBSERVATION BEDS (NON-DISTINCT PART)	545,395			15,012				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	TOTAL (sum of lines 50-199)	70,139,637			1,913,872				200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1343

WORKSHEET D  
PART V

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

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	0.337357		2,162,300			729,467		50
52	DELIVERY ROOM & LABOR ROOM	0.344451		39,903			13,745		52
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.174766		2,947,971			515,205		54
54.01	RADIOLOGY-ULTRASOUND	0.140189		656,572			92,044		54.01
60	LABORATORY	0.181481		2,175,400			394,794		60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.431162							62
65	RESPIRATORY THERAPY	0.478421		167,042			79,916		65
66	PHYSICAL THERAPY	0.568848		409,608			233,005		66
69	ELECTROCARDIOLOGY	0.123349		140,921			17,382		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.562927		217,340			122,347		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.978978		22,889			22,408		72
73	DRUGS CHARGED TO PATIENTS	0.575015		586,135			337,036		73
76	CARDIAC REHAB	1.058331		728			770		76
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
88	RURAL HEALTH CLINIC								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	CLINIC	1.173697		304,486			357,374		90
91	EMERGENCY	0.510297		1,361,884			694,965		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.023737		105,633			108,140		92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	SUBTOTAL (see instructions)			11,298,812			3,718,598		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)			11,298,812			3,718,598		202

(A) Worksheet A line numbers

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CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,090	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,879	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	3,324	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	141	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)	70	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,878	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)	141	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)	70	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	124.59	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	127.08	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,114,635	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)	212,270	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,902,365	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	3,902,365	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)						1,006.02	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)						1,889,306	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)						1,889,306	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
<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>								
43	INTENSIVE CARE UNIT							43
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						1,583,853	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						3,473,159	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)							50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)							51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)							52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)							53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES							54
55	TARGET AMOUNT PER DISCHARGE							55
56	TARGET AMOUNT (line 54 x line 55)							56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)							57
58	BONUS PAYMENT (see instructions)							58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET							59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET							60
61	IF LINE 53 ÷ 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)							61
62	RELIEF PAYMENT (see instructions)							62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)							63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						141,849	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						70,421	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						212,270	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

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					555	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,006.02	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					558,341	89
		COST	ROUTINE COST (from line 27)	column 1 + column 2	TOTAL OBSERVATION BED COST (from line 89)	OBSERVATION BED PASS-THROUGH COST (col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	CAPITAL-RELATED COST	419,370	3,902,365	0.107466	558,341	60,003	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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Micro System

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-6150

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	7,426	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	7,426	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	7,426	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 (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,143	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)	2,292,809	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	2,292,809	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	2,292,809	37

Optimizer Systems, Inc.

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-6150

WORKSHEET D-1  
PARTS III & IV

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

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

70	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST (line 37)	2,292,809	70
71	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (line 70 ÷ line 2)	308.75	71
72	PROGRAM ROUTINE SERVICE COST (line 9 x line 71)	352,901	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)	352,901	74
75	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS (from Worksheet B, Part II, column 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)	352,901	83
84	PROGRAM INPATIENT ANCILLARY SERVICES (see instructions)	241,212	84
85	UTILIZATION REVIEW--PHYSICIAN COMPENSATION (see instructions)		85
86	TOTAL PROGRAM INPATIENT OPERATING COSTS (sum of lines 83 through 85)	594,113	86

Optimizer Systems, Inc.

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1  
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	4,090	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,879	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	3,324	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	141	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)	70	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	411	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)	282	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	207	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	124.59	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	127.08	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	4,114,635	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)	212,270	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,902,365	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	3,902,365	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1  
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

						1	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,006.02	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					413,474	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)					413,474	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)	118,877	282	421.55	207	87,261	42
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>						
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 (Worksheet D-3, column 3, line 200)					679,992	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					1,180,727	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					50,604	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					71,389	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					121,993	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					1,058,734	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 + LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	IF LINE 53 + 54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (line 53) ARE LESS THAN EXPECTED COSTS (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1  
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					555	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 2	TOTAL OBSERVATION BED COST (from line 89)		OBSERVATION BED PASS-THROUGH COST col. 3 x col. 4 (see instructions)
		1	2	3	4		5
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1343

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		1,791,078		30
43	NURSERY				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.337357	552,964	186,546	50
52	DELIVERY ROOM & LABOR ROOM	0.344451			52
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.174766	616,345	107,716	54
54.01	RADIOLOGY-ULTRASOUND	0.140189	201,475	28,245	54.01
60	LABORATORY	0.181481	897,147	162,815	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.431162	81,206	35,013	62
65	RESPIRATORY THERAPY	0.478421	376,371	180,064	65
66	PHYSICAL THERAPY	0.568848	138,717	78,909	66
69	ELECTROCARDIOLOGY	0.123349	63,125	7,786	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.562927	535,779	301,604	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.978978	121,759	119,199	72
73	DRUGS CHARGED TO PATIENTS	0.575015	607,868	349,533	73
76	CARDIAC REHAB	1.058331			76
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	1.173697	17,363	20,379	90
91	EMERGENCY	0.510297	921	470	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.023737	5,445	5,574	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		4,216,485	1,583,853	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		4,216,485		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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Micro System

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z343

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.337357			50
52	DELIVERY ROOM & LABOR ROOM	0.344451			52
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.174766	5,197	908	54
54.01	RADIOLOGY-ULTRASOUND	0.140189			54.01
60	LABORATORY	0.181481	34,252	6,216	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.431162			62
65	RESPIRATORY THERAPY	0.478421	8,030	3,842	65
66	PHYSICAL THERAPY	0.568848	58,059	33,027	66
69	ELECTROCARDIOLOGY	0.123349	1,695	209	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.562927	15,663	8,817	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.978978			72
73	DRUGS CHARGED TO PATIENTS	0.575015	40,689	23,397	73
76	CARDIAC REHAB	1.058331			76
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	1.173697	74	87	90
91	EMERGENCY	0.510297			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.023737			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		163,659	76,503	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		163,659		202

(A) Worksheet A line numbers

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Micro System

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-6150

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.337357			50
52	DELIVERY ROOM & LABOR ROOM	0.344451			52
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.174766	31,143	5,443	54
54.01	RADIOLOGY-ULTRASOUND	0.140189	1,052	147	54.01
60	LABORATORY	0.181481	37,316	6,772	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.431162	5,234	2,257	62
65	RESPIRATORY THERAPY	0.478421	56,669	27,112	65
66	PHYSICAL THERAPY	0.568848	292,750	166,530	66
69	ELECTROCARDIOLOGY	0.123349	690	85	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.562927	5,629	3,169	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.978978			72
73	DRUGS CHARGED TO PATIENTS	0.575015	45,461	26,141	73
76	CARDIAC REHAB	1.058331			76
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	1.173697	3,030	3,556	90
91	EMERGENCY	0.510297			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.023737			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		478,974	241,212	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		478,974		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1343

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	ADULTS & PEDIATRICS		461,603		30
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.337357	525,725	177,357	50
52	DELIVERY ROOM & LABOR ROOM	0.344451	336,808	116,014	52
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.174766	182,702	31,930	54
54.01	RADIOLOGY-ULTRASOUND	0.140189	34,906	4,893	54.01
60	LABORATORY	0.181481	331,170	60,101	60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.431162			62
65	RESPIRATORY THERAPY	0.478421	53,496	25,594	65
66	PHYSICAL THERAPY	0.568848	3,260	1,854	66
69	ELECTROCARDIOLOGY	0.123349	4,980	614	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.562927	101,536	57,157	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.978978	18,196	17,813	72
73	DRUGS CHARGED TO PATIENTS	0.575015	226,334	130,145	73
76	CARDIAC REHAB	1.058331			76
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
88	RURAL HEALTH CLINIC				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	CLINIC	1.173697	689	809	90
91	EMERGENCY	0.510297	79,058	40,343	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.023737	15,012	15,368	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		1,913,872	679,992	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,913,872		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1343

WORKSHEET E  
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	6,667,024			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	6,667,024			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)				17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	6,733,694			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	83,803			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	2,858,461			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	3,791,430			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	3,791,430			30
31	PRIMARY PAYER PAYMENTS	624			31
32	SUBTOTAL (line 30 minus line 31)	3,790,806			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	520,797			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	458,301			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	453,104			36
37	SUBTOTAL (see instructions)	4,249,107			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	4,249,107			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	84,982			40.01
41	INTERIM PAYMENTS	4,140,016			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	24,109			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-6150

WORKSHEET E  
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

	1	101	102	
1	MEDICAL AND OTHER SERVICES (see instructions)			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)			2
3	PPS PAYMENTS			3
4	OUTLIER PAYMENT (see instructions)			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)			5
6	LINE 2 TIMES LINE 5			6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6			7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)			8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200			9
10	ORGAN ACQUISITION			10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
	REASONABLE CHARGES			
12	ANCILLARY SERVICE CHARGES			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)			13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)			14
	CUSTOMARY CHARGES			
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			15
16	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000		17
18	TOTAL CUSTOMARY CHARGES (see instructions)			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))			20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)			21
22	INTERNS AND RESIDENTS (see instructions)			22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)			23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
25	DEDUCTIBLES AND COINSURANCE (see instructions)			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)			26
27	SUBTOTAL (lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23 (see instructions)			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)			28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)			29
30	SUBTOTAL (sum of lines 27 through 29)			30
31	PRIMARY PAYER PAYMENTS			31
32	SUBTOTAL (line 30 minus line 31)			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>			
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			36
37	SUBTOTAL (see instructions)			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R			38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			39
40	SUBTOTAL (see instructions)			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)			40.01
41	INTERIM PAYMENTS			41
42	TENTATIVE SETTLEMENT (for contractor use only)			42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			44

TO BE COMPLETED BY CONTRACTOR

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

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CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1343

WORKSHEET E-1  
PART I

CHECK  HOSPITAL  SUB (OTHER)  
 APPLICABLE  IPF  SNF  
 BOXES:  IRF  SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT		
		1	2	3	4		
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		2,727,514		4,100,994	1	
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2	
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.01	04/22/2014	62,011	12/23/2013	62,775	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.02	12/23/2013	116,785			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM					3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO					3.04
		PROVIDER					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50			04/22/2014	23,753	3.50
		.51					3.51
		PROVIDER					3.52
		TO					3.53
		PROGRAM					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		178,796		39,022	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			2,906,310		4,140,016	4
	<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	.01					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	.02					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM					5.03
		TO					5.04
		PROVIDER					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
		PROVIDER					5.52
		TO					5.53
		PROGRAM					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		165,174		109,091	6.01
		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			3,071,484		4,249,107	7
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z343

WORKSHEET E-1  
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
		1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		258,144			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT 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. (1)					
		.01	12/23/2013	5,734		3.01
		.02				3.02
		.03	PROGRAM			3.03
		.04	TO			3.04
		.05	PROVIDER			3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51				3.51
		.52	PROVIDER			3.52
		.53	TO			3.53
		.54	PROGRAM			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		5,734		3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			263,878		4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
		.01				5.01
		.02				5.02
		.03	PROGRAM			5.03
		.04	TO			5.04
		.05	PROVIDER			5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52	PROVIDER			5.52
		.53	TO			5.53
		.54	PROGRAM			5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		26,599		6.01
		.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			290,477		7
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-6150

WORKSHEET E-1  
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		291,440			1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM					3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM				3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO				3.04
		PROVIDER				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		PROVIDER				3.52
		TO				3.53
		PROGRAM				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		291,440			4
<b>TO BE COMPLETED BY CONTRACTOR</b>						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT					5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.					5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM				5.03
		TO				5.04
		PROVIDER				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		PROVIDER				5.52
		TO				5.53
		PROGRAM				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)		12,351			6.01
	BASED ON THE COST REPORT (1)					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		303,791			7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

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CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK                     HOSPITAL     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	983	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,878	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	3,324	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	75,753,479	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	3,439,249	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
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)		9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	1	10

**INPATIENT HOSPITAL SERVICES UNDER PPS & CAH**

30	INITIAL/INTERIM HIT PAYMENT(S)	1	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32

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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z343

WORKSHEET E-2

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

	PART A	PART B	
	1	2	
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	214,393		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)	77,268		3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5 PROGRAM DAYS	211		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)	291,661		8
9 PRIMARY PAYER PAYMENTS (see instructions)			9
10 SUBTOTAL (line 8 minus line 9)	291,661		10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12 SUBTOTAL (line 10 minus line 11)	291,661		12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)	1,184		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)	290,477		15
16 OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
17 ALLOWABLE BAD DEBTS (see instructions)			17
17.01 ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)			17.01
18 ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			18
19 TOTAL (see instructions)	290,477		19
19.01 SEQUESTRATION ADJUSTMENT (see instructions)	5,810		19.01
20 INTERIM PAYMENTS	263,878		20
21 TENTATIVE SETTLEMENT (for contractor use only)			21
22 BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)	20,789		22
23 PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART V

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

1	INPATIENT SERVICES	3,473,159	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	3,473,159	4
5	PRIMARY PAYER PAYMENTS		5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	3,507,891	6
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>		
	REASONABLE CHARGES		
7	ROUTINE SERVICE CHARGES		7
8	ANCILLARY SERVICE CHARGES		8
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE		9
10	TOTAL REASONABLE CHARGES		10
	CUSTOMARY CHARGES		
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		11
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		12
13	RATIO OF LINE 11 TO LINE 12 (not to exceed 1.000000)	0.000000	13
14	TOTAL CUSTOMARY CHARGES (see instructions)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 14 exceeds line 6) (see instructions)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 6 exceeds line 14) (see instructions)		16
17	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	3,507,891	19
20	DEDUCTIBLES (exclude professional component)	489,680	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	3,018,211	22
23	COINSURANCE	19,832	23
24	SUBTOTAL (line 22 minus line 23)	2,998,379	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	83,074	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	73,105	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	59,661	27
28	SUBTOTAL (sum of lines 24 and 26)	3,071,484	28
29	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		29
30	SUBTOTAL (line 28 plus or minus line 29)	3,071,484	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	61,430	30.01
31	INTERIM PAYMENTS	2,906,310	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	103,744	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

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## 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 (see instructions)			
1	RESOURCE UTILIZATION GROUP (RUGS) PAYMENT	351,000	1
2	ROUTINE SERVICE OTHER PASS THROUGH COSTS		2
3	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		3
4	SUBTOTAL (sum of lines 1-3)	351,000	4
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
5	DO NOT USE THIS LINE		5
6	DEDUCTIBLES	3,724	6
7	COINSURANCE	49,888	7
8	ALLOWABLE BAD DEBTS (see instructions)	9,850	8
9	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		9
10	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	6,403	10
11	UTILIZATION REVIEW		11
12	SUBTOTAL (sum of lines 4 and 5 minus 6 & 7 plus 10 and 11) (see instructions)	303,791	12
13	INPATIENT PRIMARY PAYER PAYMENTS		13
14	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		14
15	SUBTOTAL (line 12 minus 13 + line 14)	303,791	15
15.01	SEQUESTRATION ADJUSTMENT (see instructions)	6,076	15.01
16	INTERIM PAYMENTS	291,440	16
17	TENTATIVE SETTLEMENT (for contractor use only)		17
18	BALANCE DUE PROVIDER/PROGRAM (line 15 minus 15.01, 16 and 17)	6,275	18
19	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		19

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1343

WORKSHEET E-3  
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES		3,718,598	2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)		3,718,598	4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)		3,718,598	7
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES	443,108		8
9	ANCILLARY SERVICE CHARGES	1,913,872	11,298,812	9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	<b>CUSTOMARY CHARGES</b>			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)			15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)		3,718,598	21
	<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21		3,718,598	29
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)		3,718,598	31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		3,718,598	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)		3,718,598	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)		3,718,598	40
41	INTERIM PAYMENTS		3,540,852	41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)		177,746	42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43

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## BALANCE SHEET

WORKSHEET G

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

	ASSETS (Omit Cents)	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
<b>CURRENT ASSETS</b>						
1	CASH ON HAND AND IN BANKS	8,193,875				1
2	TEMPORARY INVESTMENTS	914,922				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	8,336,631				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-2,350,000				6
7	INVENTORY	582,368				7
8	PREPAID EXPENSES	502,619				8
9	OTHER CURRENT ASSETS	242,422				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	16,422,837				11
<b>FIXED ASSETS</b>						
12	LAND	240,645				12
13	LAND IMPROVEMENTS	1,310,228				13
14	ACCUMULATED DEPRECIATION	-648,492				14
15	BUILDINGS	46,500,437				15
16	ACCUMULATED DEPRECIATION	-16,802,288				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	10,501,180				23
24	ACCUMULATED DEPRECIATION	-8,553,716				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)	33,530,175				30
<b>OTHER ASSETS</b>						
31	INVESTMENTS	14,210,613				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	354,423				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	14,565,036				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	64,518,048				36
<b>LIABILITIES AND FUND BALANCES</b>						
<b>CURRENT LIABILITIES</b>						
37	ACCOUNTS PAYABLE	1,051,217				37
38	SALARIES, WAGES & FEES PAYABLE	2,650,650				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	879,324				40
41	DEFERRED INCOME	148,193				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	2,128,163				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	6,857,547				45
<b>LONG TERM LIABILITIES</b>						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	14,684,830				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	122,965				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	14,807,795				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	21,665,342				51
<b>CAPITAL ACCOUNTS</b>						
52	GENERAL FUND BALANCE	42,852,706				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT, AND EXPANSION					58
59	TOTAL FUND BALANCES (sum of lines 52-58)	42,852,706				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	64,518,048				60

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	FUND BALANCES AT BEGINNING OF PERIOD		39,608,344		1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		3,244,362		2
3	TOTAL (sum of line 1 and line 2)		42,852,706		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)		42,852,706		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)		42,852,706		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	FUND BALANCES AT BEGINNING OF PERIOD				1
2	NET INCOME (loss) (from Worksheet G-3, line 29)				2
3	TOTAL (sum of line 1 and line 2)				3
4	ADDITIONS (credit adjustments)				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)				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)				19

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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	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	HOSPITAL	3,005,447		3,005,447	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	84,864		84,864	5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY	1,241,901		1,241,901	7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	4,332,212		4,332,212	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	4,332,212		4,332,212	17
18	ANCILLARY SERVICES	10,493,675	48,147,703	58,641,378	18
19	OUTPATIENT SERVICES		15,409,601	15,409,601	19
20	RHC		5,737,542	5,737,542	20
20.01	RHC II		612,792	612,792	20.01
20.02	RHC III		206,441	206,441	20.02
21	FQHC				21
22	HOME HEALTH AGENCY		901,635	901,635	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	PHYSICIAN PRIVATE OFFICE		580,474	580,474	27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	14,825,887	71,596,188	86,422,075	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		41,720,027	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		41,720,027	43

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## STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	86,422,075	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	43,415,736	2
3	NET PATIENT REVENUES (line 1 minus line 2)	43,006,339	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	41,720,027	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	1,286,312	5

## OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	128,799	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS		10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	177,438	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	17,844	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	160,867	22
23	GOVERNMENTAL APPROPRIATIONS	315,290	23
24	OTHER (CONSULTING CLINIC)	79,152	24
24.01	OTHER (WELLNESS)	89,736	24.01
24.02	OTHER (GRANTS)	217,543	24.02
24.03	OTHER (OTHER PROFESSIONAL INCOME)	416,449	24.03
24.04	OTHER (FOUNDATION REIMBURSEMENT)	13,211	24.04
24.05	OTHER (DONATIONS)	6,176	24.05
24.06	OTHER (OTHER INCOME)	335,545	24.06
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,958,050	25
26	TOTAL (line 5 plus line 25)	3,244,362	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	3,244,362	29

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7175

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	<b>GENERAL SERVICE COST CENTER</b>						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	100,629	6,541	4,599	46,289	32,881	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	SKILLED NURSING CARE	269,641	17,527	20,716			6
7	PHYSICAL THERAPY	22,666	1,473	4,908	6,702		7
8	OCCUPATIONAL THERAPY	8,299	539	1,702			8
9	SPEECH PATHOLOGY	528		396			9
10	MEDICAL SOCIAL SERVICES						10
11	HOME HEALTH AIDE	35,734	2,323	6,899			11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	437,497	28,403	39,220	52,991	32,881	24

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7175

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	<b>GENERAL SERVICE COST CENTER</b>						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	190,939	-9,734	181,205	-51,134	130,071	5
	<b>HHA REIMBURSABLE SERVICES</b>						
6	SKILLED NURSING CARE	307,884		307,884		307,884	6
7	PHYSICAL THERAPY	35,749		35,749		35,749	7
8	OCCUPATIONAL THERAPY	10,540		10,540		10,540	8
9	SPEECH PATHOLOGY	924		924		924	9
10	MEDICAL SOCIAL SERVICES						10
11	HOME HEALTH AIDE	44,956		44,956		44,956	11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	<b>HHA NONREIMBURSABLE SERVICES</b>						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	590,992	-9,734	581,258	-51,134	530,124	24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7175

WORKSHEET H-1  
PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	<b>GENERAL SERVICE COST CENTER</b>					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	130,071				5
	<b>HHA REIMBURSABLE SERVICES</b>					
6	SKILLED NURSING CARE	307,884				6
7	PHYSICAL THERAPY	35,749				7
8	OCCUPATIONAL THERAPY	10,540				8
9	SPEECH PATHOLOGY	924				9
10	MEDICAL SOCIAL SERVICES					10
11	HOME HEALTH AIDE	44,956				11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
	<b>HHA NONREIMBURSABLE SERVICES</b>					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	530,124				24

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7175

WORKSHEET H-1  
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	<b>GENERAL SERVICE COST CENTER</b>					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		130,071	130,071		5
	<b>HHA REIMBURSABLE SERVICES</b>					
6	SKILLED NURSING CARE		307,884	100,104	407,988	6
7	PHYSICAL THERAPY		35,749	11,623	47,372	7
8	OCCUPATIONAL THERAPY		10,540	3,427	13,967	8
9	SPEECH PATHOLOGY		924	300	1,224	9
10	MEDICAL SOCIAL SERVICES					10
11	HOME HEALTH AIDE		44,956	14,617	59,573	11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
	<b>HHA NONREIMBURSABLE SERVICES</b>					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		530,124		530,124	24

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-1  
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
<b>GENERAL SERVICE COST CENTER</b>								
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-130.071	400.053	5
<b>HHA REIMBURSABLE SERVICES</b>								
6	SKILLED NURSING CARE						307.884	6
7	PHYSICAL THERAPY						35.749	7
8	OCCUPATIONAL THERAPY						10.540	8
9	SPEECH PATHOLOGY						924	9
10	MEDICAL SOCIAL SERVICES							10
11	HOME HEALTH AIDE						44,956	11
12	SUPPLIES (see instructions)							12
13	DRUGS							13
14	DME							14
<b>HHA NONREIMBURSABLE SERVICES</b>								
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)					-130.071	400.053	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						130.071	25
26	UNIT COST MULTIPLIER						0.325134	26

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Micro System

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
1	ADMINISTRATIVE AND GENERAL			2,312	23,772	911		1
2	SKILLED NURSING CARE	407,988			63,698			2
3	PHYSICAL THERAPY	47,372			5,354			3
4	OCCUPATIONAL THERAPY	13,967			1,960			4
5	SPEECH PATHOLOGY	1,224			125			5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE	59,573			8,442			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	TOTALS (sum of lines 1-19)(2)	530,124		2,312	103,351	911		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
1	ADMINISTRATIVE AND GENERAL	2.220		19,904	49,119	4,522		1
2	SKILLED NURSING CARE				471,686	43,423		2
3	PHYSICAL THERAPY				52,726	4,854		3
4	OCCUPATIONAL THERAPY				15,927	1,466		4
5	SPEECH PATHOLOGY				1,349	124		5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE				68,015	6,261		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	TOTALS (sum of lines 1-19)(2)	2.220		19,904	658,822	60,650		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
1	ADMINISTRATIVE AND GENERAL		2,581		17,268	71,155		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
20	TOTALS (sum of lines 1-19)(2)		2,581		17,268	71,155		20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.  
 (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (sum of col.4A-23)	
		15	16	17	24	25	26	
1	ADMINISTRATIVE AND GENERAL			2,111	146,756		146,756	1
2	SKILLED NURSING CARE				515,109		515,109	2
3	PHYSICAL THERAPY				57,580		57,580	3
4	OCCUPATIONAL THERAPY				17,393		17,393	4
5	SPEECH PATHOLOGY				1,473		1,473	5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE				74,276		74,276	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	TOTALS (sum of lines 1-19)(2)			2,111	812,587		812,587	20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

- (1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
- (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2  
PART I

	HHA COST CENTER (omit cents)	ALLOCATED HHA A&G (see Pt.2)	TOTAL HHA COSTS					
		27	28					
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE	113,535	628,644					2
3	PHYSICAL THERAPY	12,691	70,271					3
4	OCCUPATIONAL THERAPY	3,834	21,227					4
5	SPEECH PATHOLOGY	325	1,798					5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE	16,371	90,647					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	TOTALS (sum of lines 1-19)(2)	146,756	812,587					20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.	0.220410						21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.  
 (2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Optimizer Systems, Inc.

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Micro System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-2  
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCESSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5.01	5.02	5.03	
1	ADMINISTRATIVE AND GENERAL		3,136	100,629	9		8	1
2	SKILLED NURSING CARE			269,641				2
3	PHYSICAL THERAPY			22,666				3
4	OCCUPATIONAL THERAPY			8,299				4
5	SPEECH PATHOLOGY			528				5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE			35,734				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	TOTALS (sum of lines 1-19)		3,136	437,497	9		8	20
21	TOTAL COST TO BE ALLOCATED		2,312	103,351	911		2,220	21
22	UNIT COST MULTIPLIER			0.236232				22
22	UNIT COST MULTIPLIER		0.737245		101.222222		277.500000	22

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Micro System

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-2  
PART II

	HHA COST CENTER	ADMITTING INPATIENT REVENUE	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	4A.06	5.06	7	8	
1	ADMINISTRATIVE AND GENERAL		901,635		49,119			1
2	SKILLED NURSING CARE				471,686			2
3	PHYSICAL THERAPY				52,726			3
4	OCCUPATIONAL THERAPY				15,927			4
5	SPEECH PATHOLOGY				1,349			5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE				68,015			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	TOTALS (sum of lines 1-19)		901,635		658,822			20
21	TOTAL COST TO BE ALLOCATED		19,904		60,650			21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER		0.022075		0.092058			22

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Micro System

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-2  
PART II

	HHA COST CENTER	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY RX CSTD REQ'S	
		9	10	11	13	14	15	
1	ADMINISTRATIVE AND GENERAL	450		8	17,093			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	TOTALS (sum of lines 1-19)	450		8	17,093			20
21	TOTAL COST TO BE ALLOCATED	2,581		17,268	71,155			21
22	UNIT COST MULTIPLIER	5.735556		2,158.500000				22
22	UNIT COST MULTIPLIER				4.162815			22

Optimizer Systems, Inc.

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Micro System

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-2  
PART II

	HHA COST CENTER	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME				
		16	17				
1	ADMINISTRATIVE AND GENERAL		3				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	TOTALS (sum of lines 1-19)		3				20
21	TOTAL COST TO BE ALLOCATED		2,111				21
22	UNIT COST MULTIPLIER						22
22	UNIT COST MULTIPLIER		703.666667				22

Optimizer Systems, Inc.

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Micro System

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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 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							
	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PER VISIT (col. 3 ÷ col. 4)
		1	2	3	4	5	
1	SKILLED NURSING CARE	2	628,644		628,644	3,072	204.64
2	PHYSICAL THERAPY	3	70,271		70,271	826	85.07
3	OCCUPATIONAL THERAPY	4	21,227		21,227	221	96.05
4	SPEECH PATHOLOGY	5	1,798		1,798	44	40.86
5	MEDICAL SOCIAL SERVICES	6					5
6	HOME HEALTH AIDE	7	90,647		90,647	900	100.72
7	TOTAL (sum of lines 1-6)		812,587		812,587	5,063	

LIMITATION COST COMPUTATION					
	PATIENT SERVICES	CBSA NO.	PART A	PROGRAM VISITS	
				NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE
		1	2	3	4
8	SKILLED NURSING CARE	99914	678	1,802	8
9	PHYSICAL THERAPY	99914	258	402	9
10	OCCUPATIONAL THERAPY	99914	65	137	10
11	SPEECH PATHOLOGY	99914	14	38	11
12	MEDICAL SOCIAL SERVICES	99914			12
13	HOME HEALTH AIDE	99914	233	651	13
14	TOTAL (sum of lines 8-13)		1,248	3,030	14

SUPPLIES AND DRUGS COSTS COMPUTATIONS							
	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 ÷ col. 4)
		1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8		22,443	22,443	39,869	0.562919
16	COST OF DRUGS	9					16

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

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records)	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED
		1	2	3	4	5
1	PHYSICAL THERAPY	66	0.568848			col. 2, line 2
2	OCCUPATIONAL THERAPY	67				col. 2, line 3
3	SPEECH PATHOLOGY	68				col. 2, line 4
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.562927	39,869	22,443	col. 2, line 15
5	DRUGS CHARGED TO PATIENTS	73	0.575015			col. 2, line 16

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Micro System

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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 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		PROGRAM VISITS			COST OF SERVICES			
PATIENT SERVICES	PART A	PART B		PART A	PART B		TOTAL PROGRAM COST (sum of cols 9-10)	
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
	6	7	8	9	10	11	12	
1 SKILLED NURSING CARE	678	1,802		138,746	368,761		507,507	1
2 PHYSICAL THERAPY	258	402		21,948	34,198		56,146	2
3 OCCUPATIONAL THERAPY	65	137		6,243	13,159		19,402	3
4 SPEECH PATHOLOGY	14	38		572	1,553		2,125	4
5 MEDICAL SOCIAL SERVICES								5
6 HOME HEALTH AIDE	233	651		23,468	65,569		89,037	6
7 TOTAL (sum of lines 1-6)	1,248	3,030		190,977	483,240		674,217	7

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES			
OTHER PATIENT SERVICES	PART A	PART B		PART A	PART B			
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
	6	7	8	9	10	11		
15 COST OF MEDICAL SUPPLIES							15	
16 COST OF DRUGS							16	

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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7175

WORKSHEET H-4  
PARTS I & II

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

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

	DESCRIPTION	PART A 1	PART B		
			NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
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

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES	PART B SERVICES	
		1	2	
10	TOTAL REASONABLE COST (see instructions)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	155,285	342,267	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	5,717	23,810	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	1,980	6,169	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES		4,501	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	857	4,209	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)	163,839	380,956	22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)	163,839	380,956	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	163,839	380,956	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)	163,839	380,956	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)	163,839	380,956	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	3,277	7,619	31.01
32	INTERIM PAYMENTS (see instructions)	160,562	373,337	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-1343

WORKSHEET L

CHECK  TITLE V  HOSPITAL  PPS  
 APPLICABLE  TITLE XVIII, PART A  SUB (OTHER)  COST METHOD  
 BOXES:  TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR THE FOLLOWING PERIOD (if line 12 is negative, enter the amount on this line)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						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
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS						30
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM						50
52	DELIVERY ROOM & LABOR ROOM						52
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	RADIOLOGY-ULTRASOUND						54.01
60	LABORATORY						60
62	WHOLE BLOOD & PACKED RED BLOOD CELLS						62
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76	CARDIAC REHAB						76
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
88	RURAL HEALTH CLINIC						88
88.01	RHC II						88.01
88.02	RHC III						88.02
90	CLINIC						90
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
101	HOME HEALTH AGENCY						101
	<b>SPECIAL PURPOSE COST CENTERS</b>						
113	INTEREST EXPENSE						113
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
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	TOTAL (sum of lines 118-201)						202

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

COMPONENT CCN: 14-3429

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1	PHYSICIAN	2,204,848	2,204,848	90,117	2,294,965	-257,489	2,037,476	1
2	PHYSICIAN ASSISTANT							2
3	NURSE PRACTITIONER	88,355	88,355		88,355		88,355	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	678,623	200,550	879,173	-48,886	830,287	-191,243	639,044
10	SUBTOTAL (sum of lines 1-9)	2,971,826	200,550	3,172,376	41,231	3,213,607	-448,732	2,764,875
<b>COSTS UNDER AGREEMENT</b>								
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
<b>OTHER HEALTH CARE COSTS</b>								
15	MEDICAL SUPPLIES		233,864	233,864		233,864		233,864
16	TRANSPORTATION (Health Care Staff)							
17	DEPRECIATION-MEDICAL EQUIPMENT				183,196	183,196		183,196
18	PROFESSIONAL LIABILITY INSURANCE		272,578	272,578		272,578		272,578
19	OTHER HEALTH CARE COSTS							
20	ALLOWABLE GME COSTS							
21	SUBTOTAL (sum of lines 15-20)		506,442	506,442	183,196	689,638		689,638
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	2,971,826	706,992	3,678,818	224,427	3,903,245	-448,732	3,454,513
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
23	PHARMACY							
24	DENTAL							
25	OPTOMETRY							
26	ALL OTHER NONREIMBURSABLE COSTS							
27	NONALLOWABLE GME COSTS							
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)							
<b>FACILITY OVERHEAD</b>								
29	FACILITY COSTS				69,274	69,274		69,274
30	ADMINISTRATIVE COSTS	692,851		692,851		692,851		692,851
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	692,851		692,851	69,274	762,125		762,125
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	3,664,677	706,992	4,371,669	293,701	4,665,370	-448,732	4,216,638

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ALLOCATION OF OVERHEAD TO RHC/FOHC SERVICES

COMPONENT CCN: 14-3429

WORKSHEET M-2

CHECK APPLICABLE BOX:  RHC       FOHC

VISITS AND PRODUCTIVITY

	POSITIONS	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
		1	2	3	4	5	
1	PHYSICIANS	5.17	26,511	4,200	21,714		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	0.94	2,503	2,100	1,974		3
4	SUBTOTAL (sum of lines 1-3)	6.11	29,014		23,688	29,014	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FOHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FOHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	6.11	29,014			29,014	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FOHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)		3,454,513	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)			11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)		3,454,513	12
13	RATIO OF RHC/FOHC SERVICES (line 10 divided by line 12)		1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)		762,125	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)		1,508,122	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)		2,270,247	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)			17
18	SUBTRACT LINE 17 FROM LINE 16		2,270,247	18
19	OVERHEAD APPLICABLE TO RHC/FOHC SERVICES (line 13 x line 18)		2,270,247	19
20	TOTAL ALLOWABLE COST OF RHC/FOHC SERVICES (sum of lines 10 and 19)		5,724,760	20

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 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 Worksheet M-2, line 20)	5,724,760	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	24,978	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	5,699,782	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	29,014	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	29,014	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	196.45	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	196.45	196.45	196.45	9
<b>CALCULATION OF SETTLEMENT</b>					
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		7,809		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		1,534,078		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, columns 1, 2, and 3)		1,534,078		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		1,149,296		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)		13,107		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)		17,495		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		1,117,274		16.04
16.05	TOTAL PROGRAM COST (see instructions)		1,134,769		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		119,990		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		203,240		19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		1,134,769		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		17,495		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		1,152,264		22
23	ALLOWABLE BAD DEBTS (see instructions)		38,099		23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		38,099		24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		1,185,791		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		23,716		26.01
27	INTERIM PAYMENTS		872,980		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		289,095		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

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

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3429

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	2,764,875	2,764,875	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000222	0.001362	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	614	3,766	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	5,212	5,481	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	5,826	9,247	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	3,454,513	3,454,513	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	2,270,247	2,270,247	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.001686	0.002677	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	3,828	6,077	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	9,654	15,324	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	86	527	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	112.26	29.08	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	67	343	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	7,521	9,974	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		24,978	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		17,495	16

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

COMPONENT CCN: 14-3429

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				842,550	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT					
	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. (1)					
		PROGRAM	.01	12/23/2013	19,608	3.01
			.02	04/22/2014	10,822	3.02
		TO	.03			3.03
		PROVIDER	.04			3.04
			.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		PROVIDER	.52			3.52
		TO	.53			3.53
		PROGRAM	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		30,430	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)				872,980	
	<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)					
			.01			5.01
			.02			5.02
		PROGRAM	.03			5.03
		TO	.04			5.04
		PROVIDER	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		PROVIDER	.52			5.52
		TO	.53			5.53
		PROGRAM	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		.01		312,811	6.01
			.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				1,185,791	
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

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

COMPONENT CCN: 14-3486

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)		
	1	2	3	4	5	6	7		
<b>FACILITY HEALTH CARE STAFF COSTS</b>									
1	PHYSICIAN	10,876	10,876		10,876	-317	10,559	1	
2	PHYSICIAN ASSISTANT							2	
3	NURSE PRACTITIONER	137,917	137,917		137,917		137,917	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	108,281	18,658	126,939	126,939	-14,119	112,820	9	
10	SUBTOTAL (sum of lines 1-9)	257,074	18,658	275,732	275,732	-14,436	261,296	10	
<b>COSTS UNDER AGREEMENT</b>									
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	
<b>OTHER HEALTH CARE COSTS</b>									
15	MEDICAL SUPPLIES		11,944	11,944	11,944		11,944	15	
16	TRANSPORTATION (Health Care Staff)							16	
17	DEPRECIATION-MEDICAL EQUIPMENT							17	
18	PROFESSIONAL LIABILITY INSURANCE							18	
19	OTHER HEALTH CARE COSTS		117,057	117,057	117,057		117,057	19	
20	ALLOWABLE GME COSTS							20	
21	SUBTOTAL (sum of lines 15-20)		129,001	129,001	129,001		129,001	21	
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	257,074	147,659	404,733	404,733	-14,436	390,297	22	
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>									
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	
<b>FACILITY OVERHEAD</b>									
29	FACILITY COSTS		24,483	24,483	7,636	32,119	32,119	29	
30	ADMINISTRATIVE COSTS	25,343	5,638	30,981		30,981	30,981	30	
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	25,343	30,121	55,464	7,636	63,100	63,100	31	
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	282,417	177,780	460,197	7,636	467,833	-14,436	453,397	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3486

WORKSHEET M-2

CHECK APPLICABLE BOX:  RHC       FQHC

VISITS AND PRODUCTIVITY

	POSITIONS	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
		1	2	3	4	5	
1	PHYSICIANS	0.05	92	4,200	210		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	0.79	4,482	2,100	1,659		3
4	SUBTOTAL (sum of lines 1-3)	0.84	4,574		1,869	4,574	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FOHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FOHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	0.84	4,574			4,574	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FOHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)					390,297	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)						11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)					390,297	12
13	RATIO OF RHC/FOHC SERVICES (line 10 divided by line 12)					1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)					63,100	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)					118,119	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)					181,219	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)						17
18	SUBTRACT LINE 17 FROM LINE 16					181,219	18
19	OVERHEAD APPLICABLE TO RHC/FOHC SERVICES (line 13 x line 18)					181,219	19
20	TOTAL ALLOWABLE COST OF RHC/FOHC SERVICES (sum of lines 10 and 19)					571,516	20

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3486

WORKSHEET M-3

CHECK  RHC  TITLE V  TITLE XIX  
 APPLICABLE BOXES:  FQHC  TITLE XVIII

**DETERMINATION OF RATE FOR RHC/FQHC SERVICES**

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	571,516	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	2,790	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	568,726	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	4,574	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	4,574	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	124.34	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	124.34	124.34	124.34	9
<b>CALCULATION OF SETTLEMENT</b>					
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		535		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		66,522		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)		6		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)		746		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)		746		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		67,268		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		73,806		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)		1,735		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)		1,581		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		42,559		16.04
16.05	TOTAL PROGRAM COST (see instructions)		44,140		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		12,488		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		11,917		19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		44,140		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		1,577		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		45,717		22
23	ALLOWABLE BAD DEBTS (see instructions)		3,960		23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		3,960		24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		49,202		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		984		26.01
27	INTERIM PAYMENTS		36,503		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		11,715		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

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

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3486

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	261,296	261,296	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000205	0.001621	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	54	424	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	606	822	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	660	1,246	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	390,297	390,297	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	181,219	181,219	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.001691	0.003192	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	306	578	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	966	1,824	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	10	79	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	96.60	23.09	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	7	39	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	676	901	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		2,790	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,577	16

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

COMPONENT CCN: 14-3486

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			36,503	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT 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. (1)				
		.01			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
		.10			3.10
		.50			3.50
		.51			3.51
		PROVIDER .52			3.52
		TO .53			3.53
		PROGRAM .54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
		.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. J-3, line 27)			36,503	
	<b>TO BE COMPLETED BY CONTRACTOR</b>				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
		.01			5.01
		.02			5.02
		PROGRAM .03			5.03
		TO .04			5.04
		PROVIDER .05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		PROVIDER .52			5.52
		TO .53			5.53
		PROGRAM .54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
		.99			5.99
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		12,699	6.01
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			49,202	
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

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

COMPONENT CCN: 14-3488

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
<b>FACILITY HEALTH CARE STAFF COSTS</b>								
1	PHYSICIAN	75,332	75,332		75,332	-8,332	67,000	1
2	PHYSICIAN ASSISTANT							2
3	NURSE PRACTITIONER	24,402	24,402		24,402		24,402	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	109,824	11,221	121,045	23,362	144,407	144,407	9
10	SUBTOTAL (sum of lines 1-9)	209,558	11,221	220,779	23,362	244,141	-8,332	235,809
<b>COSTS UNDER AGREEMENT</b>								
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
<b>OTHER HEALTH CARE COSTS</b>								
15	MEDICAL SUPPLIES		12,711	12,711		12,711	12,711	15
16	TRANSPORTATION (Health Care Staff)							16
17	DEPRECIATION-MEDICAL EQUIPMENT							17
18	PROFESSIONAL LIABILITY INSURANCE							18
19	OTHER HEALTH CARE COSTS		52,329	52,329		52,329	52,329	19
20	ALLOWABLE GME COSTS							20
21	SUBTOTAL (sum of lines 15-20)		65,040	65,040		65,040	65,040	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	209,558	76,261	285,819	23,362	309,181	-8,332	300,849
<b>COSTS OTHER THAN RHC/FQHC SERVICES</b>								
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
<b>FACILITY OVERHEAD</b>								
29	FACILITY COSTS		20,938	20,938		20,938	20,938	29
30	ADMINISTRATIVE COSTS	27,951	5,688	33,639		33,639	3	33,642
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	27,951	26,626	54,577		54,577	3	54,580
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	237,509	102,887	340,396	23,362	363,758	-8,329	355,429

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3488

WORKSHEET M-2

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	POSITIONS	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
		1	2	3	4	5	
1	PHYSICIANS	0.34	1,554	4,200	1,428		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	0.39	1,287	2,100	819		3
4	SUBTOTAL (sum of lines 1-3)	0.73	2,841		2,247	2,841	4
5	VISITING NURSE						5
6	CLINICAL PSYCHOLOGIST						6
7	CLINICAL SOCIAL WORKER						7
7.01	MEDICAL NUTRITION THERAPIST (FOHC only)						7.01
7.02	DIABETES SELF MANAGEMENT TRAINING (FOHC only)						7.02
8	TOTAL FTEs AND VISITS (sum of lines 4-7)	0.73	2,841			2,841	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FOHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)					300,849	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)						11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)					300,849	12
13	RATIO OF RHC/FOHC SERVICES (line 10 divided by line 12)					1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)					54,580	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)					93,346	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)					147,926	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)						17
18	SUBTRACT LINE 17 FROM LINE 16					147,926	18
19	OVERHEAD APPLICABLE TO RHC/FOHC SERVICES (line 13 x line 18)					147,926	19
20	TOTAL ALLOWABLE COST OF RHC/FOHC SERVICES (sum of lines 10 and 19)					448,775	20

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FOHC SERVICES

COMPONENT CCN: 14-3488

WORKSHEET M-3

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

**DETERMINATION OF RATE FOR RHC/FOHC SERVICES**

1	TOTAL ALLOWABLE COST OF RHC/FOHC SERVICES (from Worksheet M-2, line 20)	448,775	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	1,132	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	447,643	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	2,841	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)		5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	2,841	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	157.57	7

		CALCULATION OF LIMIT (1)			
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1	(SEE INSTR.)	
		1	2	3	
8	PER VISIT PAYMENT LIMIT (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	RATE FOR PROGRAM COVERED VISITS (see instructions)	157.57	157.57	157.57	9
<b>CALCULATION OF SETTLEMENT</b>					
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		236		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		37,187		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, columns 1, 2, and 3)		37,187		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		31,310		16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (see instructions)(from provider's records)		936		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS (see instructions)		1,112		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS (see instructions)		24,755		16.04
16.05	TOTAL PROGRAM COST (see instructions)		25,867		16.05
17	PRIMARY PAYER PAYMENTS				17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		5,131		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FOHC SERVICES (see instructions) (from contractor records)		5,049		19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		25,867		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		445		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		26,312		22
23	ALLOWABLE BAD DEBTS (see instructions)		1,209		23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		1,209		24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		27,376		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		548		26.01
27	INTERIM PAYMENTS		19,854		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		6,974		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

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

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3488

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	235,809	235,809	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000151	0.000552	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	36	130	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	364	229	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	400	359	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	300,849	300,849	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	147,926	147,926	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.001330	0.001193	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	197	176	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	597	535	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	6	22	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	99.50	24.32	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	3	6	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	299	146	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		1,132	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		445	16

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CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2013 To: 04/30/2014	Run Date: 09/22/2014 Run Time: 13:02 Version: 2014.03
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC  
PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3488

WORKSHEET M-5

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			16,973	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.01	04/22/2014	2,881	3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.02			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM			3.03
		TO			3.04
		PROVIDER			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
		PROVIDER			3.52
		TO			3.53
		PROGRAM			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		2,881	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)			19,854	
	<b>TO BE COMPLETED BY CONTRACTOR</b>				
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	.01			5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	.02			5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM			5.03
		TO			5.04
		PROVIDER			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		PROVIDER			5.52
		TO			5.53
		PROGRAM			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01		7,522	6.01
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			27,376	
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER	NPR DATE (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.

14-3488 MEDICAID SUPPLEMENTAL & NON-ALLOWABLE 14-3486 SCHEDULE OF EXPENSES NONE 14-3429		CLINIC NAME	REPORTING PERIOD	ATTACHMENT #1
COST CENTER (OMIT CENTS)		CMH Rural Health Clinic Oblong	FROM: 5-1-13 TO: 4-30-14	
1	2	3	4	5
COMPENSATION	OTHER	TOTAL COL.1&2	RECLASSI- FICATIONS	RECLASSIFIED TRIAL BALANCE COL.3&4
1	2	3	4	5
ADJUSTMENTS INCREASES (DECREASES)	NET EXPENSES COL.5&6	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 HMIHK Case Management		-		-
16 WIC( Women, Infants, & Children)		-		-
17 Fundraising & Public Relations		-		-
18 Social Services		-		-
19 Unlicensed Social Workers		-		-
20 Others(specify)		-		-
21		-		-
22		-		-
23		-		-
24		-		-
25 Non-Allowable Subtotal(sum of lines 15 - 24)		-		-
26 Totals for schedule C (sum of lines 12,13, &25)		-		-

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

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

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

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