CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 09/21/2016 Time: 16:11 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CRAWFORD MEMORIAL HOSPITAL (14-1343) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 05/01/2015 and ending 04/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		294,357	-344,801			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		91,309				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		290				7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			216,420			10
10.01	HEALTH CLINIC - RHC II			19,015			10.01
10.02	HEALTH CLINIC - RHC III			8,005			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		385,956	-101,361			200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1000 NORTH ALLEN STREET	P.O. Box:		1
2	City: ROBINSON	State: IL	ZIP Code: 62454	County: CRAWFORD	2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	CRAWFORD MEMORIAL HOSPITAL	14-1343	99914	1	05 / 01 / 2005	N	O	P	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	CRAWFORD MEMORIAL HOSPITAL	14-Z343	99914		05 / 01 / 2005	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF	CRAWFORD MEMORIAL HOSPITAL LTC	14-6150	99914		03 / 29 / 2012	N	P	N	9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	CRAWFORD MEMORIAL HHA	14-7175	99914		08 / 01 / 1979	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	CMH RURAL HEALTH CLINIC	14-3429	99914		11 / 11 / 1996	N	O	N	15
15.01	Hospital-Based Health Clinic - RHC II	PALESTINE RURAL HEALTH CLINIC	14-3486	99914		11 / 21 / 2006	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	OBLONG RURAL HEALTH CLINIC	14-3488	99914		05 / 01 / 2007	N	O	N	15.02
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 05 / 01 / 2015	To: 04 / 30 / 2016	20
21	Type of control (see instructions)	11		21

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

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

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2		26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.			35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.			37

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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

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

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

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

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

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

Inpatient Psychiatric Faciltiy PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:				118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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

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WORKSHEET S-2
PART I

All Providers

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

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

141	Name:	Contractor's Name:	Contractor's Number:		141
142	Street:	P.O. Box:			142
143	City:	State:	ZIP Code:		143
144	Are provider based physicians' costs included in Worksheet A?			Y	144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.			N	N 145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.			N	146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.			N	147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.			N	148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.			N	149

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

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

Multicampus

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

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		05 / 01 / 2015	04 / 30 / 2016	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/14/2016	Y	06/14/2016	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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

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

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

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

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

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

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

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

Cost Report Preparer Contact Information				
41	First name: BRENT	Last name: KOCHEL	Title: MANAGER	41
42	Employer: KEB			42
43	Phone number: 6185291040	E-mail Address: BRENTK@KEBCPA.COM		43

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,150	81,840.00		1,365	484	2,939	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						344		344	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,150	81,840.00		1,709	484	3,283	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						232	369	13
14	Total (see instructions)		25	9,150	81,840.00		1,709	716	3,652	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	17,568			1,152		7,593	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					3,488		4,767	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					7,175		28,152	26
26.01	RHC II	88.01					611		4,717	26.01
26.02	RHC III	88.02					615		6,248	26.02
27	Total (sum of lines 14-26)		73							27
28	Observation Bed Days							110	466	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							39	63	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					469	213	850	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)		269.63			469	213	850	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		20.48						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		9.46						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		50.36						26
26.01	RHC II		4.43						26.01
26.02	RHC III		5.54						26.02
27	Total (sum of lines 14-26)		359.90						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7175** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County: CLICK HERE TO ENTER

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours		495		85	580	1
2	Unduplicated Census Count (see instructions)						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	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)	1.02		1.02	4
5	Other Administrative Personnel	1.06		1.06	5
6	Direct Nursing Service	4.64		4.64	6
7	Nursing Supervisor				7
8	Physical Therapy Service	0.33		0.33	8
9	Physical Therapy Supervisor	0.34		0.34	9
10	Occupational Therapy Service	0.12		0.12	10
11	Occupational Therapy Supervisor	0.04		0.04	11
12	Speech Pathology Service	0.01		0.01	12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.89		1.89	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	99914	20

PPS ACTIVITY

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits	1,555	372	63	30	2,020	21
22	Skilled Nursing Visit Charges	319,280	76,202	12,978	6,180	414,640	22
23	Physical Therapy Visits	718	35	4	11	768	23
24	Physical Therapy Visit Charges	150,978	7,365	844	2,321	161,508	24
25	Occupational Therapy Visits	166		2		168	25
26	Occupational Therapy Visit Charges	35,026		422		35,448	26
27	Speech Pathology Visits	36				36	27
28	Speech Pathology Visit Charges	7,596				7,596	28
29	Medical Social Service Visits	1				1	29
30	Medical Social Service Visit Charges	291				291	30
31	Home Health Aide Visits	407	88			495	31
32	Home Health Aide Visit Charges	39,379	8,486			47,865	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,883	495	69	41	3,488	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	552,550	92,053	14,244	8,501	667,348	35
36	Total Number of Episodes (standard/non-outlier)	157		24	3	184	36
37	Total Number of Ourlier Episodes		11			11	37
38	Total Non-Routine Medical Supply Charges	30,810	7,096	3,407	202	41,515	38

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	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	14		14	7
8	RHL				8
9	RMX	9		9	9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC	30		30	15
16	RVB	16		16	16
17	RVA	1		1	17
18	RHC	155		155	18
19	RHB	96		96	19
20	RHA	326		326	20
21	RMC	103		103	21
22	RMB				22
23	RMA	248		248	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	17		17	28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	12		12	36
37	LE2				37
38	LE1	4		4	38
39	LD2				39
40	LD1	44		44	40
41	LC2				41
42	LC1	14		14	42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1	2		2	50
51	CB2				51
52	CB1	22		22	52
53	CA2				53
54	CA1	7		7	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1	3		3	70
71	PD2				71

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1	15		15	72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	14		14	76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL	1,152		1,152	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 catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing	818,632	64.67%		202
203	Recruitment				203
204	Retention of employees				204
205	Training	1,865	0.15%		205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	1,265,799			207

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-3429** **WORKSHEET S-8**
STATISTICAL DATA

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

Clinic Address and Identification:

1	Street: 1000 N ALLEN	1
2	City: ROBINSON State: IL ZIP Code: 62454 County: CRAWFORD	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-3486** **WORKSHEET S-8**
STATISTICAL DATA

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

Clinic Address and Identification:

1	Street: 209 EAST GRAND PRAIRIE	1
2	City: PALESTINE State: IL ZIP Code: 62451 County: CRAWFORD	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-3488** **WORKSHEET S-8**
STATISTICAL DATA

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

Clinic Address and Identification:

1	Street: 1000 N ALLEN	1
2	City: ROBINSON State: IL ZIP Code: 62454 County: CRAWFORD	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.455540	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,900,573	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	1,790,665	5
6	Medicaid charges	17,951,815	6
7	Medicaid cost (line 1 times line 6)	8,177,770	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.	3,486,532	8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,486,532	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	828,701	1,053,651	1,882,352	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	377,506	479,980	857,486	21
22	Partial payment by patients approved for charity care	51,374	65,332	116,706	22
23	Cost of charity care (line 21 minus line 22)	326,132	414,648	740,780	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,918,232	26
27	Medicare bad debts for the entire hospital complex (see instructions)	462,990	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,455,242	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	662,921	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,403,701	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,890,233	31

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		2,193,524	2,193,524	159,622	2,353,146	-74,495	2,278,651	1
2	00200	Cap Rel Costs-Mvble Equip		916,147	916,147	5,552	921,699	-103,349	818,350	2
3	00300	Other Cap Rel Costs		28,424	28,424	-28,424			-0-	3
4	00400	Employee Benefits Department	196,531	3,892,642	4,089,173	8,026	4,097,199	-282,346	3,814,853	4
5.01	00540	NONPATIENT TELEPHONES		1	1	32,845	32,846		32,846	5.01
5.02	00550	DATA PROCESSING	236,295	722,792	959,087		959,087		959,087	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	155,220	47,763	202,983		202,983		202,983	5.03
5.04	00570	ADMITTING	375,181	82,477	457,658	-33,550	424,108		424,108	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	299,779	392,279	692,058		692,058		692,058	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	580,262	2,396,498	2,976,760		2,976,760	-348,962	2,627,798	5.06
7	00700	Operation of Plant	455,359	1,258,024	1,713,383	39,727	1,753,110	-1,252	1,751,858	7
8	00800	Laundry & Linen Service	85,630	80,279	165,909		165,909		165,909	8
9	00900	Housekeeping	328,691	184,952	513,643		513,643		513,643	9
10	01000	Dietary	498,769	431,097	929,866	-440,500	489,366		489,366	10
11	01100	Cafeteria				440,500	440,500	-208,389	232,111	11
13	01300	Nursing Administration	621,092	67,840	688,932	43,867	732,799		732,799	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	631,111	350,337	981,448		981,448	-12,245	969,203	15
16	01600	Medical Records & Library	596,905	185,496	782,401	4,226	786,627	-4,365	782,262	16
17	01700	Social Service	59,030	6,863	65,893		65,893		65,893	17
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,356,996	470,260	2,827,256	-221,455	2,605,801	-403,708	2,202,093	30
43	04300	Nursery				77,364	77,364		77,364	43
44	04400	Skilled Nursing Facility	818,632	214,852	1,033,484	159,721	1,193,205		1,193,205	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	966,575	403,332	1,369,907	995,498	2,365,405	-862,759	1,502,646	50
52	05200	Delivery Room & Labor Room				144,091	144,091		144,091	52
53	05300	Anesthesiology	711,296	284,202	995,498	-995,498				53
54	05400	Radiology-Diagnostic	693,145	609,824	1,302,969	-14,261	1,288,708	-600	1,288,108	54
54.01	05401	RADIOLOGY-ULTRASOUND		208,455	208,455		208,455		208,455	54.01
60	06000	Laboratory	592,356	1,022,180	1,614,536	-110,095	1,504,441		1,504,441	60
62	06200	Whole Blood & Packed Red Blood Cells				110,095	110,095		110,095	62
65	06500	Respiratory Therapy	380,236	138,771	519,007		519,007	-20,000	499,007	65
66	06600	Physical Therapy	997,694	219,750	1,217,444	-10,005	1,207,439		1,207,439	66
69	06900	Electrocardiology	21,802	1,623	23,425		23,425		23,425	69
71	07100	Medical Supplies Charged to Patients		718,908	718,908	13,827	732,735		732,735	71
72	07200	Impl. Dev. Charged to Patients		251,085	251,085		251,085		251,085	72
73	07300	Drugs Charged to Patients		1,727,413	1,727,413	14,261	1,741,674		1,741,674	73
76	03950	CARDIAC REHAB	26,512	9,053	35,565		35,565		35,565	76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	4,146,169	637,932	4,784,101	205,409	4,989,510	-334,190	4,655,320	88
88.01	08801	RHC II	306,715	201,059	507,774	7,581	515,355	-14,570	500,785	88.01
88.02	08802	RHC III	459,584	188,339	647,923	95,963	743,886	-5,692	738,194	88.02
90	09000	Clinic	2,133,265	1,740,014	3,873,279	-42,846	3,830,433	-2,423,073	1,407,360	90
90.01	09001	PAIN MANAGEMENT CLINIC	15,730	2,734	18,464		18,464		18,464	90.01
91	09100	Emergency	779,476	1,646,467	2,425,943		2,425,943	-1,167,252	1,258,691	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	521,349	141,769	663,118	-13,215	649,903	-25,767	624,136	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		912,358	912,358	-598,857	313,501	-313,501		113
118		SUBTOTALS (sum of lines 1-117)	21,047,387	24,987,815	46,035,202	49,469	46,084,671	-6,606,515	39,478,156	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	119,380	281,621	401,001	21,162	422,163		422,163	192
194	07950	NONREIMBURSEABLE								194
194.01	07951	PROFESSIONAL BUILDINGS		171,958	171,958	-64,504	107,454		107,454	194.01
194.02	07952	FOUNDATION SERVICES	27,069	6,750	33,819		33,819		33,819	194.02
194.03	07953	WELLNESS	95,150	19,434	114,584	-6,127	108,457		108,457	194.03
194.04	07954	RENTED SPACE								194.04
200		TOTAL (sum of lines 118-199)	21,288,986	25,467,578	46,756,564		46,756,564	-6,606,515	40,150,049	200

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		13,827	1
500	Total reclassifications					13,827	500
	Code Letter - A						
1	LTC ADMITTING COSTS	D	Skilled Nursing Facility	44	578	127	1
500	Total reclassifications				578	127	500
	Code Letter - D						
1	R/C CAFETERIA COSTS	F	Cafeteria	11	236,279	204,221	1
500	Total reclassifications				236,279	204,221	500
	Code Letter - F						
1	R/C COST OF BLOOD	G	Whole Blood & Packed Red Bloo	62		110,095	1
500	Total reclassifications					110,095	500
	Code Letter - G						
1	PBX COST	H	NONPATIENT TELEPHONES	5.01	26,921	5,924	1
500	Total reclassifications				26,921	5,924	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		29,787	1
2			Rural Health Clinic	88		178,551	2
3			RHC II	88.01		7,581	3
4			RHC III	88.02		65,108	4
5			Clinic	90		19,553	5
6			Home Health Agency	101		612	6
7			WELLNESS	194.03		1,899	7
500	Total reclassifications					303,091	500
	Code Letter - J						
1	R/C SNF DEPR	K	Skilled Nursing Facility	44		159,016	1
500	Total reclassifications					159,016	500
	Code Letter - K						
1	R/C LABOR/DEL & NB COSTS	L	Nursery	43	66,513	10,851	1
2			Delivery Room & Labor Room	52	123,881	20,210	2
500	Total reclassifications				190,394	31,061	500
	Code Letter - L						
1	R/C TRANSCRIPTION TXFR	N	Medical Records & Library	16		4,226	1
2							2
500	Total reclassifications					4,226	500
	Code Letter - N						
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	O	Drugs Charged to Patients	73		14,261	1
500	Total reclassifications					14,261	500
	Code Letter - O						
1	R/C OR COST	Q	Operating Room	50	711,296	284,202	1
500	Total reclassifications				711,296	284,202	500
	Code Letter - Q						
1	R/C PALESTINE/OBLONG DRS	R					1
2			Physicians' Private Offices	192		21,162	2
3			RHC III	88.02		29,836	3
500	Total reclassifications					50,998	500
	Code Letter - R						
1	HEALTHWORKS COST	U	Employee Benefits Department	4	6,967	1,059	1
500	Total reclassifications				6,967	1,059	500
	Code Letter - U						
1	UTILITIES	V	Operation of Plant	7		39,727	1
2							2
3							3
500	Total reclassifications					39,727	500
	Code Letter - V						
1	INTEREST EXPENSE	W	Cap Rel Costs-Bldg & Fixt	1		598,857	1
500	Total reclassifications					598,857	500
	Code Letter - W						

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RHC UTILITIES & MAINTENANCE	X	Rural Health Clinic	88		72,131	1
500	Total reclassifications					72,131	500
	Code Letter - X						
1	RECLASS PROPERTY TAXES	Z	Physical Therapy	66		21,141	1
2			RHC III	88.02		1,019	2
500	Total reclassifications					22,160	500
	Code Letter - Z						
1	R/C NURSE EDUCATION	AA	Nursing Administration	13	43,867		1
500	Total reclassifications				43,867		500
	Code Letter - AA						
	GRAND TOTAL (Increases)				1,216,302	1,914,983	

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

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	R/C HHA MED SUPPLIES	A	Home Health Agency	101		13,827		1
500	Total reclassifications					13,827		500
	Code letter - A							
1	LTC ADMITTING COSTS	D	ADMITTING	5.04	578	127		1
500	Total reclassifications				578	127		500
	Code letter - D							
1	R/C CAFETERIA COSTS	F	Dietary	10	236,279	204,221		1
500	Total reclassifications				236,279	204,221		500
	Code letter - F							
1	R/C COST OF BLOOD	G	Laboratory	60		110,095		1
500	Total reclassifications					110,095		500
	Code letter - G							
1	PBX COST	H	ADMITTING	5.04	26,921	5,924		1
500	Total reclassifications				26,921	5,924		500
	Code letter - H							
1	R/C DEPR OBLONG CLINIC	I					9	1
500	Total reclassifications							500
	Code letter - I							
1	R/C DEPR PROF BLDGS	J	Cap Rel Costs-Bldg & Fixt	1		303,091	9	1
2							9	2
3							9	3
4							9	4
5							9	5
6							9	6
7							9	7
500	Total reclassifications					303,091		500
	Code letter - J							
1	R/C SNF DEPR	K	Cap Rel Costs-Bldg & Fixt	1		159,016	9	1
500	Total reclassifications					159,016		500
	Code letter - K							
1	R/C LABOR/DEL & NB COSTS	L	Adults & Pediatrics	30	190,394	31,061		1
2								2
500	Total reclassifications				190,394	31,061		500
	Code letter - L							
1	R/C TRANSCRIPTION TXFR	N	Rural Health Clinic	88		266		1
2			Clinic	90		3,960		2
500	Total reclassifications					4,226		500
	Code letter - N							
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	O	Radiology-Diagnostic	54		14,261		1
500	Total reclassifications					14,261		500
	Code letter - O							
1	R/C OR COST	Q	Anesthesiology	53	711,296	284,202		1
500	Total reclassifications				711,296	284,202		500
	Code letter - Q							
1	R/C PALESTINE/OBLONG DRS	R	Rural Health Clinic	88		45,007		1
2			Clinic	90		5,991		2
3								3
500	Total reclassifications					50,998		500
	Code letter - R							
1	HEALTHWORKS COST	U	WELLNESS	194.03	6,967	1,059		1
500	Total reclassifications				6,967	1,059		500
	Code letter - U							
1	UTILITIES	V						1
2			Physical Therapy	66		31,146		2
3			Clinic	90		8,581		3
500	Total reclassifications					39,727		500
	Code letter - V							
1	INTEREST EXPENSE	W	Interest Expense	113		598,857	11	1
500	Total reclassifications					598,857		500
	Code letter - W							

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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		72,131		1
500	Total reclassifications					72,131		500
	Code letter - X							
1	RECLASS PROPERTY TAXES	Z	PROFESSIONAL BUILDINGS	194.01		22,160		1
2								2
500	Total reclassifications					22,160		500
	Code letter - Z							
1	R/C NURSE EDUCATION	AA	Clinic	90	43,867			1
500	Total reclassifications				43,867			500
	Code letter - AA							
	GRAND TOTAL (Decreases)				1,216,302	1,914,983		

(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

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	290,645	50,000		50,000		340,645		1
2	Land Improvements	1,310,228				164,162	1,146,066		2
3	Buildings and Fixtures	48,321,243	2,767,758		2,767,758	947,563	50,141,438		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	12,056,823	1,944,396		1,944,396	1,468,303	12,532,916		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	61,978,939	4,762,154		4,762,154	2,580,028	64,161,065		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	61,978,939	4,762,154		4,762,154	2,580,028	64,161,065		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	2,193,524						2,193,524	1
2	Cap Rel Costs-Mvble Equip	916,147						916,147	2
3	Total (sum of lines 1-2)	3,109,671						3,109,671	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	51,628,150		51,628,150	0.804665			22,872	22,872	1
2	Cap Rel Costs-Mvble Equ	12,532,915		12,532,915	0.195335			5,552	5,552	2
3	Total (sum of lines 1-2)	64,161,065		64,161,065	1.000000			28,424	28,424	3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,731,417	-74,495	598,857			22,872	2,278,651	1
2	Cap Rel Costs-Mvble Equip	812,798					5,552	818,350	2
3	Total (sum of lines 1-2)	2,544,215	-74,495	598,857			28,424	3,097,001	3

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

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	A	-74,495	Cap Rel Costs-Bldg & Fixt	1	10	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,575,960				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	-208,389	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	-4,365	Medical Records & Library	16		18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-103,349	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYS RECRUITING	A	-146,482	OTHER ADMINISTRATIVE AND GENERAL	5.06		33
33.11	EMPLOYEE INJURY	A	-10,006	Employee Benefits Department	4		33.11
34	ADVERTISING	A	-108,629	OTHER ADMINISTRATIVE AND GENERAL	5.06		34
35	TV ADMINISTRATION	A	-6,858	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	-43,908	Employee Benefits Department	4		38
39	OTHER A & G	A	-39,041	OTHER ADMINISTRATIVE AND GENERAL	5.06		39
40	EMPLOYEE SALES - PHARMACY	B	-11,791	Pharmacy	15		40
41							41
42	CONSULTING CLINIC	B	-79,542	Clinic	90		42
42.11	OTHER INCOME ROBINSON RHC	B	-185,099	Rural Health Clinic	88		42.11
42.22	OTHER INCOME PALESTINE RHC	B	-14,484	RHC II	88.01		42.22
43							43
44	PHYSICIAN EXPENSES	A	-1,099,353	Clinic	90		44
45	PHYSICIAN EXPENSES	A	-87,220	Employee Benefits Department	4		45
46	PHYSICIAN EXPENSES	A	-149,091	Rural Health Clinic	88		46
47	PHYSICIAN EXPENSES	A	-86	RHC II	88.01		47
48	PHYSICIAN EXPENSES	A	-5,692	RHC III	88.02		48
48.05	PHYSICIAN EXPENSES	A	-222,473	Clinic	90		48.05
48.09	PHYSICIAN EXPENSES	A	-11,920	Employee Benefits Department	4		48.09
48.12	PHYSICIAN EXPENSES	A	-148,673	Clinic	90		48.12
48.15	PHYSICIAN EXPENSES	A	-55,243	Employee Benefits Department	4		48.15
48.18	PHYSICIAN EXPENSES	A	-25,553	Employee Benefits Department	4		48.18
48.75	BOND ISSUE COSTS	A	-313,501	Interest Expense	113		48.75
49							49
49.01	NONALLOW CARELINK COST	A	-25,767	Home Health Agency	101		49.01
49.02	MISC INCOME	B	-5,435	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.02
49.03	AHA & IHA DUES	A	-20,213	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.03
49.04	OB LOCUM TENUMS	A	-15,000	Adults & Pediatrics	30		49.04
49.05	NONPATIENT CPR	B	-1,505	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.05
49.07	DONATIONS, PROJECTS	B	-40,845	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.07
49.12	CRNA FEES	A	-208,260	Operating Room	50		49.12

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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	
49.13	ADMIN CLAIMS FEES	A	47,587	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.13
49.15	PHYSICIAN FEES	A	-873,032	Clinic	90		49.15
49.16	CRNA	A	-654,499	Operating Room	50		49.16
49.17	CRNA	A	-48,496	Employee Benefits Department	4		49.17
49.18	NONALLOW ADS	A	-27,541	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.18
49.20	MRI RENT	B	-600	Radiology-Diagnostic	54		49.20
49.25	340B REVENUE	B	-454	Pharmacy	15		49.25
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-6,606,515				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.

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

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	65	Respiratory Therapy AGGREGATE	20,000	20,000						1
2	91	Emergency AGGREGATE	1,493,031	1,167,252	325,779					2
3	30	Adults & Pediatrics AGGREGATE	388,708	388,708						3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,901,739	1,575,960	325,779					200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	65	Respiratory Therapy AGGREGATE							20,000	1
2	91	Emergency AGGREGATE							1,167,252	2
3	30	Adults & Pediatrics AGGREGATE							388,708	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,575,960	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)					35	1
2	Line 1 multiplied by 15 hours per week					525	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					175	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate						7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		1,185.00				9
10	AHSEA (see instructions)		78.66				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	39.33	39.33				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)	93,212	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)	93,212	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)	93,212	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)	93,212	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)	6,883	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)	6,883	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,883	28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)	6,883	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

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

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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

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56	17.00				17.00	47
48	Overtime rate (see instructions)	117.99					48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	2,006					49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)	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
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)	78.66					52
53	Overtime cost limitation (line 51 times line 52)	163,613					53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)	2,006					54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1,337					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.)	669				669	56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	93,212	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	6,883	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)	669	60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	100,764	63
64	Total cost of outside supplier services (from provider records)	85,546	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	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONES	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,278,651	2,278,651					1
2	Cap Rel Costs-Mvble Equip	818,350		818,350				2
4	Employee Benefits Department	3,814,853	18,557	1,504	3,834,914			4
5.01	NONPATIENT TELEPHONES	32,846			5,458	38,304		5.01
5.02	DATA PROCESSING	959,087	17,807	217,461	47,903	280	1,242,538	5.02
5.03	PURCHASING RECEIVING AND STORES	202,983	47,378	4,818	31,467	559		5.03
5.04	ADMITTING	424,108	15,664	3,703	70,483	839		5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	692,058	25,907	7,291	60,772	932	783,172	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	2,627,798	192,854	12,741	117,633	1,398	459,366	5.06
7	Operation of Plant	1,751,858	176,247	13,485	92,312	746		7
8	Laundry & Linen Service	165,909	54,406	3,708	17,359	93		8
9	Housekeeping	513,643	17,743	2,551	66,634	93		9
10	Dietary	489,366	71,784	11,534	53,213	652		10
11	Cafeteria	232,111	42,128		47,899			11
13	Nursing Administration	732,799	22,650		125,910	559		13
14	Central Services & Supply							14
15	Pharmacy	969,203	27,171	51,092	127,941	932		15
16	Medical Records & Library	782,262	66,599	19,268	121,007	1,491		16
17	Social Service	65,893	1,071		11,967	186		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,202,093	238,967	81,243	437,139	4,194		30
43	Nursery	77,364	8,936		15,567	186		43
44	Skilled Nursing Facility	1,193,205		8,876	166,074	2,610		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,502,646	422,452	137,744	207,462	2,144		50
52	Delivery Room & Labor Room	144,091	26,807		25,114			52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,288,108	72,792	70,579	140,517	1,398		54
54.01	RADIOLOGY-ULTRASOUND	208,455	10,393	1,980				54.01
60	Laboratory	1,504,441	36,599	21,214	120,085	652		60
62	Whole Blood & Packed Red Blood Cells	110,095	2,357					62
65	Respiratory Therapy	499,007	24,642	24,011	77,083	559		65
66	Physical Therapy	1,207,439	214,775	11,138	202,257	652		66
69	Electrocardiology	23,425	5,828	984	4,420	186		69
71	Medical Supplies Charged to Patients	732,735	32,464					71
72	Impl. Dev. Charged to Patients	251,085	11,336					72
73	Drugs Charged to Patients	1,741,674						73
76	CARDIAC REHAB	35,565	65,399	10,481	5,375	186		76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,655,320		25,607	810,309	6,340		88
88.01	RHC II	500,785		932	62,161	652		88.01
88.02	RHC III	738,194		7,901	92,015	2,423		88.02
90	Clinic	1,407,360		22,566	156,915	4,753		90
90.01	PAIN MANAGEMENT CLINIC	18,464		54	3,189			90.01
91	Emergency	1,258,691	205,711	33,752	158,018	1,118		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	624,136		658	105,690	839		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	39,478,156	2,177,424	808,876	3,787,348	37,652	1,242,538	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		15,000					190
192	Physicians' Private Offices	422,163			24,201			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	107,454		3,421		466		194.01
194.02	FOUNDATION SERVICES	33,819	1,071		5,488	93		194.02
194.03	WELLNESS	108,457		6,053	17,877	93		194.03
194.04	RENTED SPACE		85,156					194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	40,150,049	2,278,651	818,350	3,834,914	38,304	1,242,538	202

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	
	GENERAL SERVICE COST CENTERS							
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	287,205						5.03
5.04	ADMITTING	928	515,725					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	619		1,570,751				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	4,023			3,415,813	3,415,813		5.06
7	Operation of Plant	7,118			2,041,766	189,858	2,231,624	7
8	Laundry & Linen Service	3,095			244,570	22,742	52,864	8
9	Housekeeping	5,571			606,235	56,372	17,240	9
10	Dietary	3,404			629,953	58,577	69,750	10
11	Cafeteria				322,138	29,955	40,934	11
13	Nursing Administration	309			882,227	82,036	22,008	13
14	Central Services & Supply							14
15	Pharmacy	3,404			1,179,743	109,701	26,401	15
16	Medical Records & Library	1,547			992,174	92,259	64,711	16
17	Social Service				79,117	7,357	1,041	17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,666	119,559	62,112	3,153,973	293,278	232,194	30
43	Nursery		16,169	8,024	126,246	11,739	8,682	43
44	Skilled Nursing Facility	5,880			1,376,645	128,010	226,656	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	22,902	76,108	250,461	2,621,919	243,804	410,485	50
52	Delivery Room & Labor Room		38,752	19,231	253,995	23,618	26,047	52
53	Anesthesiology							53
54	Radiology-Diagnostic	10,832	31,834	339,975	1,956,035	181,886	70,729	54
54.01	RADIOLOGY-ULTRASOUND		11,787	65,084	297,699	27,682	10,098	54.01
60	Laboratory	49,209	56,007	328,929	2,117,136	196,866	35,562	60
62	Whole Blood & Packed Red Blood Cells		6,164	7,185	125,801	11,698	2,290	62
65	Respiratory Therapy	3,095	20,229	33,461	682,087	63,425	23,944	65
66	Physical Therapy	1,547	38,212	87,051	1,763,071	163,943	208,688	66
69	Electrocardiology		3,283	13,470	51,596	4,798	5,663	69
71	Medical Supplies Charged to Patients	73,661	36,127	42,430	917,417	85,308	31,544	71
72	Impl. Dev. Charged to Patients	25,688	11,314	11,413	310,836	28,904	11,014	72
73	Drugs Charged to Patients		42,127	112,680	1,896,481	176,348		73
76	CARDIAC REHAB	1,238		4,602	122,846	11,423	63,545	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	27,854			5,525,430	513,802		88
88.01	RHC II	2,166			566,696	52,695		88.01
88.02	RHC III	3,095			843,628	78,446		88.02
90	Clinic	9,285	33	34,626	1,635,538	152,084	281,373	90
90.01	PAIN MANAGEMENT CLINIC				21,707	2,018		90.01
91	Emergency	4,333	8,020	129,108	1,798,751	167,260	199,880	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,404		20,909	755,636	70,264		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	282,873	515,725	1,570,751	39,314,905	3,338,156	2,143,343	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				15,000	1,395	14,575	190
192	Physicians' Private Offices	3,404			449,768	41,823		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	309			111,650	10,382		194.01
194.02	FOUNDATION SERVICES				40,471	3,763	1,041	194.02
194.03	WELLNESS	619			133,099	12,376	72,665	194.03
194.04	RENTED SPACE				85,156	7,918		194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	287,205	515,725	1,570,751	40,150,049	3,415,813	2,231,624	202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
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	320,176						8
9	Housekeeping		679,847					9
10	Dietary	7,493	20,514	786,287				10
11	Cafeteria		12,039		405,066			11
13	Nursing Administration		6,473		12,137	1,004,881		13
14	Central Services & Supply							14
15	Pharmacy		7,765		10,620	58,819	1,393,049	15
16	Medical Records & Library		19,032		22,757			16
17	Social Service		306		1,517	10,651		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	104,710	68,291	257,382	53,099	273,400		30
43	Nursery	2,004	2,554		3,034	17,328		43
44	Skilled Nursing Facility	87,979	66,662	486,183	30,342	172,995		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	36,781	120,727	20,413	30,342	173,782		50
52	Delivery Room & Labor Room	5,143	7,661		4,551	27,958		52
53	Anesthesiology							53
54	Radiology-Diagnostic	18,522	20,802		18,205			54
54.01	RADIOLOGY-ULTRASOUND		2,970					54.01
60	Laboratory	147	10,459		19,722			60
62	Whole Blood & Packed Red Blood Cells		674					62
65	Respiratory Therapy	2,773	7,042		10,620	58,912		65
66	Physical Therapy		61,377		22,757			66
69	Electrocardiology		1,666					69
71	Medical Supplies Charged to Patients		9,277					71
72	Impl. Dev. Charged to Patients		3,239					72
73	Drugs Charged to Patients						1,393,049	73
76	CARDIAC REHAB		18,689					76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,471	111,897		75,854			88
88.01	RHC II	574			9,103			88.01
88.02	RHC III	97			6,068			88.02
90	Clinic	3,824			28,825			90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency	42,854	58,787	22,309	22,757	131,134		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,756		13,654	79,902		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	317,372	641,659	786,287	395,964	1,004,881	1,393,049	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,287					190
192	Physicians' Private Offices				3,034			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		12,223					194.01
194.02	FOUNDATION SERVICES		306		1,517			194.02
194.03	WELLNESS	2,804	21,372		4,551			194.03
194.04	RENTED SPACE							194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	320,176	679,847	786,287	405,066	1,004,881	1,393,049	202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
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	1,190,933						16
17	Social Service		99,989					17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	48,818	56,994	4,542,139		4,542,139		30
43	Nursery	6,307		177,894		177,894		43
44	Skilled Nursing Facility		33,996	2,609,468		2,609,468		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	196,854		3,855,107		3,855,107		50
52	Delivery Room & Labor Room	15,115		364,088		364,088		52
53	Anesthesiology							53
54	Radiology-Diagnostic	267,231		2,533,410		2,533,410		54
54.01	RADIOLOGY-ULTRASOUND	51,154		389,603		389,603		54.01
60	Laboratory	258,528		2,638,420		2,638,420		60
62	Whole Blood & Packed Red Blood Cells	5,647		146,110		146,110		62
65	Respiratory Therapy	26,299		875,102		875,102		65
66	Physical Therapy	68,420		2,288,256		2,288,256		66
69	Electrocardiology	10,587		74,310		74,310		69
71	Medical Supplies Charged to Patients	33,348		1,076,894		1,076,894		71
72	Impl. Dev. Charged to Patients	8,970		362,963		362,963		72
73	Drugs Charged to Patients	88,563		3,554,441		3,554,441		73
76	CARDIAC REHAB	3,617		220,120		220,120		76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			6,231,454		6,231,454		88
88.01	RHC II			629,068		629,068		88.01
88.02	RHC III			928,239		928,239		88.02
90	Clinic			2,101,644		2,101,644		90
90.01	PAIN MANAGEMENT CLINIC			23,725		23,725		90.01
91	Emergency	101,475	6,999	2,552,206		2,552,206		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,000	924,212		924,212		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,190,933	99,989	39,098,873		39,098,873		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			35,257		35,257		190
192	Physicians' Private Offices			494,625		494,625		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS			134,255		134,255		194.01
194.02	FOUNDATION SERVICES			47,098		47,098		194.02
194.03	WELLNESS			246,867		246,867		194.03
194.04	RENTED SPACE			93,074		93,074		194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,190,933	99,989	40,150,049		40,150,049		202

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 TELEPHONES	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		18,557	1,504	20,061	20,061		4
5.01	NONPATIENT TELEPHONES					29	29	5.01
5.02	DATA PROCESSING		17,807	217,461	235,268	250		5.02
5.03	PURCHASING RECEIVING AND STORES		47,378	4,818	52,196	165		5.03
5.04	ADMITTING		15,664	3,703	19,367	369	1	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		25,907	7,291	33,198	318	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		192,854	12,741	205,595	615	1	5.06
7	Operation of Plant		176,247	13,485	189,732	483	1	7
8	Laundry & Linen Service		54,406	3,708	58,114	91		8
9	Housekeeping		17,743	2,551	20,294	348		9
10	Dietary		71,784	11,534	83,318	278		10
11	Cafeteria		42,128		42,128	250		11
13	Nursing Administration		22,650		22,650	658		13
14	Central Services & Supply							14
15	Pharmacy		27,171	51,092	78,263	669	1	15
16	Medical Records & Library		66,599	19,268	85,867	633	1	16
17	Social Service		1,071		1,071	63		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,497	238,967	81,243	335,707	2,286	3	30
43	Nursery		8,936		8,936	81		43
44	Skilled Nursing Facility	10,516		8,876	19,392	868	2	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	50,155	422,452	137,744	610,351	1,085	2	50
52	Delivery Room & Labor Room		26,807		26,807	131		52
53	Anesthesiology							53
54	Radiology-Diagnostic		72,792	70,579	143,371	735	1	54
54.01	RADIOLOGY-ULTRASOUND		10,393	1,980	12,373			54.01
60	Laboratory		36,599	21,214	57,813	628		60
62	Whole Blood & Packed Red Blood Cells		2,357		2,357			62
65	Respiratory Therapy		24,642	24,011	48,653	403		65
66	Physical Therapy		214,775	11,138	225,913	1,058		66
69	Electrocardiology		5,828	984	6,812	23		69
71	Medical Supplies Charged to Patients		32,464		32,464			71
72	Impl. Dev. Charged to Patients		11,336		11,336			72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB		65,399	10,481	75,880	28		76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			25,607	25,607	4,245	7	88
88.01	RHC II			932	932	325		88.01
88.02	RHC III	12,600		7,901	20,501	481	2	88.02
90	Clinic			22,566	22,566	820	4	90
90.01	PAIN MANAGEMENT CLINIC			54	54	17		90.01
91	Emergency		205,711	33,752	239,463	826	1	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			658	658	553	1	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	88,768	2,177,424	808,876	3,075,068	19,812	29	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		15,000		15,000			190
192	Physicians' Private Offices	1,500			1,500	127		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS			3,421	3,421			194.01
194.02	FOUNDATION SERVICES		1,071		1,071	29		194.02
194.03	WELLNESS			6,053	6,053	93		194.03
194.04	RENTED SPACE		85,156		85,156			194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	90,268	2,278,651	818,350	3,187,269	20,061	29	202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

	COST CENTER DESCRIPTIONS	DATA PROCESSING	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	GENERAL SERVICE COST CENTERS							
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	235,518						5.02
5.03	PURCHASING RECEIVING AND STORES		52,361					5.03
5.04	ADMITTING		169	19,906				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	148,447	113		182,077			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	87,071	734			294,016		5.06
7	Operation of Plant		1,298			16,342	207,856	7
8	Laundry & Linen Service		564			1,958	4,924	8
9	Housekeeping		1,016			4,852	1,606	9
10	Dietary		621			5,042	6,497	10
11	Cafeteria					2,578	3,813	11
13	Nursing Administration		56			7,061	2,050	13
14	Central Services & Supply							14
15	Pharmacy		621			9,443	2,459	15
16	Medical Records & Library		282			7,941	6,027	16
17	Social Service					633	97	17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,580	4,614	7,199	25,244	21,627	30
43	Nursery			624	930	1,010	809	43
44	Skilled Nursing Facility		1,072			11,019	21,111	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		4,175	2,937	29,029	20,986	38,233	50
52	Delivery Room & Labor Room			1,496	2,229	2,033	2,426	52
53	Anesthesiology							53
54	Radiology-Diagnostic		1,975	1,229	39,429	15,656	6,588	54
54.01	RADIOLOGY-ULTRASOUND			455	7,543	2,383	941	54.01
60	Laboratory		8,971	2,162	38,123	16,946	3,312	60
62	Whole Blood & Packed Red Blood Cells			238	833	1,007	213	62
65	Respiratory Therapy		564	781	3,878	5,459	2,230	65
66	Physical Therapy		282	1,475	10,089	14,112	19,437	66
69	Electrocardiology			127	1,561	413	527	69
71	Medical Supplies Charged to Patients		13,428	1,394	4,918	7,343	2,938	71
72	Impl. Dev. Charged to Patients		4,683	437	1,323	2,488	1,026	72
73	Drugs Charged to Patients			1,626	13,060	15,179		73
76	CARDIAC REHAB		226		533	983	5,919	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		5,078			44,222		88
88.01	RHC II		395			4,536		88.01
88.02	RHC III		564			6,752		88.02
90	Clinic		1,693	1	4,013	13,091	26,207	90
90.01	PAIN MANAGEMENT CLINIC					174		90.01
91	Emergency		790	310	14,964	14,397	18,617	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		621		2,423	6,048		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	235,518	51,571	19,906	182,077	287,331	199,634	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					120	1,357	190
192	Physicians' Private Offices		621			3,600		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		56			894		194.01
194.02	FOUNDATION SERVICES					324	97	194.02
194.03	WELLNESS		113			1,065	6,768	194.03
194.04	RENTED SPACE					682		194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	235,518	52,361	19,906	182,077	294,016	207,856	202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
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	65,651						8
9	Housekeeping		28,116					9
10	Dietary	1,537	848	98,141				10
11	Cafeteria		498		49,267			11
13	Nursing Administration		268		1,476	34,219		13
14	Central Services & Supply							14
15	Pharmacy		321		1,292	2,003	95,072	15
16	Medical Records & Library		787		2,768			16
17	Social Service		13		185	363		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	21,468	2,824	32,125	6,458	9,309		30
43	Nursery	411	106		369	590		43
44	Skilled Nursing Facility	18,040	2,757	60,683	3,690	5,891		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,542	4,992	2,548	3,690	5,918		50
52	Delivery Room & Labor Room	1,055	317		554	952		52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,798	860		2,214			54
54.01	RADIOLOGY-ULTRASOUND		123					54.01
60	Laboratory	30	433		2,399			60
62	Whole Blood & Packed Red Blood Cells		28					62
65	Respiratory Therapy	569	291		1,292	2,006		65
66	Physical Therapy		2,538		2,768			66
69	Electrocardiology		69					69
71	Medical Supplies Charged to Patients		384					71
72	Impl. Dev. Charged to Patients		134					72
73	Drugs Charged to Patients						95,072	73
76	CARDIAC REHAB		773					76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	917	4,628		9,224			88
88.01	RHC II	118			1,107			88.01
88.02	RHC III	20			738			88.02
90	Clinic	784			3,506			90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency	8,787	2,431	2,785	2,768	4,466		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		114		1,661	2,721		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	65,076	26,537	98,141	48,159	34,219	95,072	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		177					190
192	Physicians' Private Offices				369			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		505					194.01
194.02	FOUNDATION SERVICES		13		185			194.02
194.03	WELLNESS	575	884		554			194.03
194.04	RENTED SPACE							194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	65,651	28,116	98,141	49,267	34,219	95,072	202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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		
	GENERAL SERVICE COST CENTERS							
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	104,306						16
17	Social Service		2,425					17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,276	1,381	476,101		476,101		30
43	Nursery	552		14,418		14,418		43
44	Skilled Nursing Facility		825	145,350		145,350		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,241		748,729		748,729		50
52	Delivery Room & Labor Room	1,324		39,324		39,324		52
53	Anesthesiology							53
54	Radiology-Diagnostic	23,404		239,260		239,260		54
54.01	RADIOLOGY-ULTRASOUND	4,480		28,298		28,298		54.01
60	Laboratory	22,643		153,460		153,460		60
62	Whole Blood & Packed Red Blood Cells	495		5,171		5,171		62
65	Respiratory Therapy	2,303		68,429		68,429		65
66	Physical Therapy	5,992		283,664		283,664		66
69	Electrocardiology	927		10,459		10,459		69
71	Medical Supplies Charged to Patients	2,921		65,790		65,790		71
72	Impl. Dev. Charged to Patients	786		22,213		22,213		72
73	Drugs Charged to Patients	7,757		132,694		132,694		73
76	CARDIAC REHAB	317		84,659		84,659		76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			93,928		93,928		88
88.01	RHC II			7,413		7,413		88.01
88.02	RHC III			29,058		29,058		88.02
90	Clinic			72,685		72,685		90
90.01	PAIN MANAGEMENT CLINIC			245		245		90.01
91	Emergency	8,888	170	319,663		319,663		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		49	14,849		14,849		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	104,306	2,425	3,055,860		3,055,860		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			16,654		16,654		190
192	Physicians' Private Offices			6,217		6,217		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS			4,876		4,876		194.01
194.02	FOUNDATION SERVICES			1,719		1,719		194.02
194.03	WELLNESS			16,105		16,105		194.03
194.04	RENTED SPACE			85,838		85,838		194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	104,306	2,425	3,187,269		3,187,269		202

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 TELEPHONES #OF PHONES	DATA PROCESSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	106,339						1
2	Cap Rel Costs-Mvble Equip		990,384					2
4	Employee Benefits Department	866	1,820	18,916,887				4
5.01	NONPATIENT TELEPHONES			26,921	411			5.01
5.02	DATA PROCESSING	831	263,177	236,295	3	10,000		5.02
5.03	PURCHASING RECEIVING AND STORES	2,211	5,831	155,220	6		928	5.03
5.04	ADMITTING	731	4,481	347,682	9		3	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,209	8,824	299,779	10	6,303	2	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,000	15,420	580,262	15	3,697	13	5.06
7	Operation of Plant	8,225	16,320	455,359	8		23	7
8	Laundry & Linen Service	2,539	4,487	85,630	1		10	8
9	Housekeeping	828	3,087	328,691	1		18	9
10	Dietary	3,350	13,959	262,490	7		11	10
11	Cafeteria	1,966		236,279				11
13	Nursing Administration	1,057		621,092	6		1	13
14	Central Services & Supply							14
15	Pharmacy	1,268	61,832	631,111	10		11	15
16	Medical Records & Library	3,108	23,319	596,905	16		5	16
17	Social Service	50		59,030	2			17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,152	98,322	2,156,327	45		28	30
43	Nursery	417		76,788	2			43
44	Skilled Nursing Facility		10,742	819,210	28		19	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,715	166,701	1,023,372	23		74	50
52	Delivery Room & Labor Room	1,251		123,881				52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397	85,416	693,145	15		35	54
54.01	RADIOLOGY-ULTRASOUND	485	2,396					54.01
60	Laboratory	1,708	25,674	592,356	7		159	60
62	Whole Blood & Packed Red Blood Cells	110						62
65	Respiratory Therapy	1,150	29,058	380,236	6		10	65
66	Physical Therapy	10,023	13,479	997,694	7		5	66
69	Electrocardiology	272	1,191	21,802	2			69
71	Medical Supplies Charged to Patients	1,515					238	71
72	Impl. Dev. Charged to Patients	529					83	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	3,052	12,684	26,512	2		4	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		30,990	3,997,078	68		90	88
88.01	RHC II		1,128	306,629	7		7	88.01
88.02	RHC III		9,562	453,892	26		10	88.02
90	Clinic		27,310	774,032	51		30	90
90.01	PAIN MANAGEMENT CLINIC		65	15,730				90.01
91	Emergency	9,600	40,847	779,476	12		14	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		796	521,349	9		11	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	101,615	978,918	18,682,255	404	10,000	914	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices			119,380			11	192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		4,140		5		1	194.01
194.02	FOUNDATION SERVICES	50		27,069	1			194.02
194.03	WELLNESS		7,326	88,183	1		2	194.03
194.04	RENTED SPACE	3,974						194.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,278,651	818,350	3,834,914	38,304	1,242,538	287,205	202
203	Unit Cost Multiplier (Wkst. B, Part I)	21.428178	0.826296	0.202724	93.197080	124.253800	309.488147	203
204	Cost to be allocated (Per Wkst. B, Part II)			20,061	29	235,518	52,361	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001060	0.070560	23.551800	56.423491	205

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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	
	GENERAL SERVICE COST CENTERS							
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	12,495,101						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		76,685,822					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-3,415,813	36,734,236			5.06
7	Operation of Plant				2,041,766	107,182		7
8	Laundry & Linen Service				244,570	2,539	197,913	8
9	Housekeeping				606,235	828		9
10	Dietary				629,953	3,350	4,632	10
11	Cafeteria				322,138	1,966		11
13	Nursing Administration				882,227	1,057		13
14	Central Services & Supply							14
15	Pharmacy				1,179,743	1,268		15
16	Medical Records & Library				992,174	3,108		16
17	Social Service				79,117	50		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,896,641	3,032,361		3,153,973	11,152	64,724	30
43	Nursery	391,744	391,744		126,246	417	1,239	43
44	Skilled Nursing Facility				1,376,645	10,886	54,383	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,843,966	12,227,730		2,621,919	19,715	22,736	50
52	Delivery Room & Labor Room	938,907	938,886		253,995	1,251	3,179	52
53	Anesthesiology							53
54	Radiology-Diagnostic	771,292	16,598,148		1,956,035	3,397	11,449	54
54.01	RADIOLOGY-ULTRASOUND	285,576	3,177,470		297,699	485		54.01
60	Laboratory	1,356,965	16,058,619		2,117,136	1,708	91	60
62	Whole Blood & Packed Red Blood Cells	149,340	350,785		125,801	110		62
65	Respiratory Therapy	490,117	1,633,576		682,087	1,150	1,714	65
66	Physical Therapy	925,818	4,249,933		1,763,071	10,023		66
69	Electrocardiology	79,550	657,639		51,596	272		69
71	Medical Supplies Charged to Patients	875,297	2,071,456		917,417	1,515		71
72	Impl. Dev. Charged to Patients	274,111	557,187		310,836	529		72
73	Drugs Charged to Patients	1,020,655	5,501,151		1,896,481			73
76	CARDIAC REHAB		224,693		122,846	3,052		76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				5,525,430		2,764	88
88.01	RHC II				566,696		355	88.01
88.02	RHC III				843,628		60	88.02
90	Clinic	807	1,690,454		1,635,538	13,514	2,364	90
90.01	PAIN MANAGEMENT CLINIC				21,707			90.01
91	Emergency	194,315	6,303,202		1,798,751	9,600	26,490	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,020,788		755,636			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	12,495,101	76,685,822	-3,415,813	35,899,092	102,942	196,180	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				15,000	700		190
192	Physicians' Private Offices				449,768			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				111,650			194.01
194.02	FOUNDATION SERVICES				40,471	50		194.02
194.03	WELLNESS				133,099	3,490	1,733	194.03
194.04	RENTED SPACE				85,156			194.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	515,725	1,570,751		3,415,813	2,231,624	320,176	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.041274	0.020483		0.092987	20.820884	1.617761	203
204	Cost to be allocated (Per Wkst. B, Part II)	19,906	182,077		294,016	207,856	65,651	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.001593	0.002374		0.008004	1.939281	0.331716	205

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINIS-TRATION NURSING HOURS	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
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	111,020						9
10	Dietary	3,350	44,373					10
11	Cafeteria	1,966		267				11
13	Nursing Administration	1,057		8	247,568			13
14	Central Services & Supply							14
15	Pharmacy	1,268		7	14,491	969,203		15
16	Medical Records & Library	3,108		15			73,974,580	16
17	Social Service	50		1	2,624			17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,152	14,525	35	67,356		3,032,361	30
43	Nursery	417		2	4,269		391,744	43
44	Skilled Nursing Facility	10,886	27,437	20	42,620			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,715	1,152	20	42,814		12,227,730	50
52	Delivery Room & Labor Room	1,251		3	6,888		938,886	52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397		12			16,598,148	54
54.01	RADIOLOGY-ULTRASOUND	485					3,177,470	54.01
60	Laboratory	1,708		13			16,058,619	60
62	Whole Blood & Packed Red Blood Cells	110					350,785	62
65	Respiratory Therapy	1,150		7	14,514		1,633,576	65
66	Physical Therapy	10,023		15			4,249,933	66
69	Electrocardiology	272					657,639	69
71	Medical Supplies Charged to Patients	1,515					2,071,456	71
72	Impl. Dev. Charged to Patients	529					557,187	72
73	Drugs Charged to Patients					969,203	5,501,151	73
76	CARDIAC REHAB	3,052					224,693	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	18,273		50				88
88.01	RHC II			6				88.01
88.02	RHC III			4				88.02
90	Clinic			19				90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency	9,600	1,259	15	32,307		6,303,202	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	450		9	19,685			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	104,784	44,373	261	247,568	969,203	73,974,580	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices			2				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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	679,847	786,287	405,066	1,004,881	1,393,049	1,190,933	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.123644	17.719942	1,517.101124	4.059010	1.437314	0.016099	203
204	Cost to be allocated (Per Wkst. B, Part II)	28,116	98,141	49,267	34,219	95,072	104,306	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.253252	2.211728	184.520599	0.138221	0.098093	0.001410	205

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME						
		17						
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits 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
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	57						30
43	Nursery							43
44	Skilled Nursing Facility	34						44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & 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
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency	7						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	2						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
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 centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	99,989						202
203	Unit Cost Multiplier (Wkst. B, Part I)	999.890000						203
204	Cost to be allocated (Per Wkst. B, Part II)	2,425						204
205	Unit Cost Multiplier (Wkst. B, Part II)	24.250000						205

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,542,139		4,542,139		4,542,139	30
43	Nursery	177,894		177,894		177,894	43
44	Skilled Nursing Facility	2,609,468		2,609,468		2,609,468	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,855,107		3,855,107		3,855,107	50
52	Delivery Room & Labor Room	364,088		364,088		364,088	52
53	Anesthesiology						53
54	Radiology-Diagnostic	2,533,410		2,533,410		2,533,410	54
54.01	RADIOLOGY-ULTRASOUND	389,603		389,603		389,603	54.01
60	Laboratory	2,638,420		2,638,420		2,638,420	60
62	Whole Blood & Packed Red Blood Cells	146,110		146,110		146,110	62
65	Respiratory Therapy	875,102		875,102		875,102	65
66	Physical Therapy	2,288,256		2,288,256		2,288,256	66
69	Electrocardiology	74,310		74,310		74,310	69
71	Medical Supplies Charged to Patients	1,076,894		1,076,894		1,076,894	71
72	Impl. Dev. Charged to Patients	362,963		362,963		362,963	72
73	Drugs Charged to Patients	3,554,441		3,554,441		3,554,441	73
76	CARDIAC REHAB	220,120		220,120		220,120	76
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	6,231,454		6,231,454		6,231,454	88
88.01	RHC II	629,068		629,068		629,068	88.01
88.02	RHC III	928,239		928,239		928,239	88.02
90	Clinic	2,101,644		2,101,644		2,101,644	90
90.01	PAIN MANAGEMENT CLINIC	23,725		23,725		23,725	90.01
91	Emergency	2,552,206		2,552,206		2,552,206	91
92	Observation Beds (Non-Distinct Part)	564,587		564,587		564,587	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	924,212		924,212		924,212	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	39,663,460		39,663,460		39,663,460	200
201	Less Observation Beds	564,587		564,587		564,587	201
202	Total (line 200 minus line 201)	39,098,873		39,098,873		39,098,873	202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	3,022,571		3,022,571				30
43	Nursery	391,744		391,744				43
44	Skilled Nursing Facility	1,256,993		1,256,993				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,843,966	10,383,765	12,227,731	0.315276	0.315276	0.315276	50
52	Delivery Room & Labor Room	915,593	23,293	938,886	0.387787	0.387787	0.387787	52
53	Anesthesiology							53
54	Radiology-Diagnostic	771,292	15,826,856	16,598,148	0.152632	0.152632	0.152632	54
54.01	RADIOLOGY-ULTRASOUND	285,576	2,891,894	3,177,470	0.122614	0.122614	0.122614	54.01
60	Laboratory	1,356,965	14,701,654	16,058,619	0.164299	0.164299	0.164299	60
62	Whole Blood & Packed Red Blood Cells	155,340	195,445	350,785	0.416523	0.416523	0.416523	62
65	Respiratory Therapy	490,117	1,143,459	1,633,576	0.535697	0.535697	0.535697	65
66	Physical Therapy	925,818	3,324,115	4,249,933	0.538422	0.538422	0.538422	66
69	Electrocardiology	79,550	578,089	657,639	0.112995	0.112995	0.112995	69
71	Medical Supplies Charged to Patients	875,297	1,196,158	2,071,455	0.519873	0.519873	0.519873	71
72	Impl. Dev. Charged to Patients	274,111	283,076	557,187	0.651420	0.651420	0.651420	72
73	Drugs Charged to Patients	1,020,655	4,480,496	5,501,151	0.646127	0.646127	0.646127	73
76	CARDIAC REHAB		224,693	224,693	0.979648	0.979648	0.979648	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		5,799,187	5,799,187				88
88.01	RHC II		639,185	639,185				88.01
88.02	RHC III		942,710	942,710				88.02
90	Clinic	20,807	1,669,646	1,690,453	1.243243	1.243243	1.243243	90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency	194,315	6,108,887	6,303,202	0.404906	0.404906	0.404906	91
92	Observation Beds (Non-Distinct Part)	14,086	501,558	515,644	1.094916	1.094916	1.094916	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,020,788	1,020,788				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	13,894,796	71,934,954	85,829,750				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	13,894,796	71,934,954	85,829,750				202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1343** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.315276		2,409,791			759,749		50
52	Delivery Room & Labor Room	0.387787							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.152632		5,416,324			826,704		54
54.01	RADIOLOGY-ULTRASOUND	0.122614		913,828			112,048		54.01
60	Laboratory	0.164299		6,022,292			989,457		60
62	Whole Blood & Packed Red Blood	0.416523		109,555			45,632		62
65	Respiratory Therapy	0.535697		447,616			239,787		65
66	Physical Therapy	0.538422		942,008			507,198		66
69	Electrocardiology	0.112995		279,656			31,600		69
71	Medical Supplies Charged to Pat	0.519873		202,525			105,287		71
72	Impl. Dev. Charged to Patients	0.651420		136,535			88,942		72
73	Drugs Charged to Patients	0.646127		1,983,006			1,281,274		73
76	CARDIAC REHAB	0.979648		59,736			58,520		76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.243243		638,344			793,617		90
90.01	PAIN MANAGEMENT CLINIC								90.01
91	Emergency	0.404906		1,970,709			797,952		91
92	Observation Beds (Non-Distinct	1.094916		218,670			239,425		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			21,750,595			6,877,192		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			21,750,595			6,877,192		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z343** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.315276							50
52	Delivery Room & Labor Room	0.387787							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.152632							54
54.01	RADIOLOGY-ULTRASOUND	0.122614							54.01
60	Laboratory	0.164299							60
62	Whole Blood & Packed Red Blood	0.416523							62
65	Respiratory Therapy	0.535697							65
66	Physical Therapy	0.538422							66
69	Electrocardiology	0.112995							69
71	Medical Supplies Charged to Pat	0.519873							71
72	Impl. Dev. Charged to Patients	0.651420							72
73	Drugs Charged to Patients	0.646127							73
76	CARDIAC REHAB	0.979648							76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.243243							90
90.01	PAIN MANAGEMENT CLINIC								90.01
91	Emergency	0.404906							91
92	Observation Beds (Non-Distinct	1.094916							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-6150** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
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							62
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-6150** | **WORKSHEET D PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	12,227,731							50
52	Delivery Room & Labor Room	938,886							52
53	Anesthesiology								53
54	Radiology-Diagnostic	16,598,148			17,257				54
54.01	RADIOLOGY-ULTRASOUND	3,177,470			7,773				54.01
60	Laboratory	16,058,619			36,106				60
62	Whole Blood & Packed Red Blood	350,785			2,207				62
65	Respiratory Therapy	1,633,576			34,753				65
66	Physical Therapy	4,249,933			401,348				66
69	Electrocardiology	657,639			762				69
71	Medical Supplies Charged to Pat	2,071,455			5,246				71
72	Impl. Dev. Charged to Patients	557,187							72
73	Drugs Charged to Patients	5,501,151			21,485				73
76	CARDIAC REHAB	224,693							76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	5,799,187							88
88.01	RHC II	639,185							88.01
88.02	RHC III	942,710							88.02
90	Clinic	1,690,453							90
90.01	PAIN MANAGEMENT CLINIC								90.01
91	Emergency	6,303,202							91
92	Observation Beds (Non-Distinct	515,644							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	80,137,654			526,937				200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-6150** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.315276							50
52	Delivery Room & Labor Room	0.387787							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.152632							54
54.01	RADIOLOGY-ULTRASOUND	0.122614							54.01
60	Laboratory	0.164299							60
62	Whole Blood & Packed Red Blood	0.416523							62
65	Respiratory Therapy	0.535697							65
66	Physical Therapy	0.538422							66
69	Electrocardiology	0.112995							69
71	Medical Supplies Charged to Pat	0.519873							71
72	Impl. Dev. Charged to Patients	0.651420							72
73	Drugs Charged to Patients	0.646127							73
76	CARDIAC REHAB	0.979648							76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.243243							90
90.01	PAIN MANAGEMENT CLINIC								90.01
91	Emergency	0.404906							91
92	Observation Beds (Non-Distinct	1.094916							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	476,101	43,686	432,415	3,405	126.99	484	61,463	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	14,418		14,418	369	39.07	232	9,064	43
44	Skilled Nursing Facility	145,350		145,350	7,593	19.14			44
45	Nursing Facility								45
200	Total (lines 30-199)	635,869		592,183	11,367		716	70,527	200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1343** **WORKSHEET D PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	748,729	12,227,731	0.061232	598,798	36,666	50
52	Delivery Room & Labor Room	39,324	938,886	0.041884	399,663	16,739	52
53	Anesthesiology						53
54	Radiology-Diagnostic	239,260	16,598,148	0.014415	174,440	2,515	54
54.01	RADIOLOGY-ULTRASOUND	28,298	3,177,470	0.008906	37,871	337	54.01
60	Laboratory	153,460	16,058,619	0.009556	356,278	3,405	60
62	Whole Blood & Packed Red Blood	5,171	350,785	0.014741			62
65	Respiratory Therapy	68,429	1,633,576	0.041889	58,367	2,445	65
66	Physical Therapy	283,664	4,249,933	0.066746	30,400	2,029	66
69	Electrocardiology	10,459	657,639	0.015904	6,450	103	69
71	Medical Supplies Charged to Pat	65,790	2,071,455	0.031760	109,412	3,475	71
72	Impl. Dev. Charged to Patients	22,213	557,187	0.039866	52,671	2,100	72
73	Drugs Charged to Patients	132,694	5,501,151	0.024121	203,418	4,907	73
76	CARDIAC REHAB	84,659	224,693	0.376776			76
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	93,928	5,799,187	0.016197			88
88.01	RHC II	7,413	639,185	0.011598			88.01
88.02	RHC III	29,058	942,710	0.030824			88.02
90	Clinic	72,685	1,690,453	0.042997	3,552	153	90
90.01	PAIN MANAGEMENT CLINIC	245					90.01
91	Emergency	319,663	6,303,202	0.050714	57,734	2,928	91
92	Observation Beds (Non-Distinct	59,179	515,644	0.114767	13,086	1,502	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,464,321	80,137,654		2,102,140	79,304	200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	3,405		484		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	369		232		43
44	Skilled Nursing Facility	7,593				44
45	Nursing Facility					45
200	Total (lines 30-199)	11,367		716		200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1343** | **WORKSHEET D PART IV**

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
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							62
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1343** | **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	12,227,731			598,798				50
52	Delivery Room & Labor Room	938,886			399,663				52
53	Anesthesiology								53
54	Radiology-Diagnostic	16,598,148			174,440				54
54.01	RADIOLOGY-ULTRASOUND	3,177,470			37,871				54.01
60	Laboratory	16,058,619			356,278				60
62	Whole Blood & Packed Red Blood	350,785							62
65	Respiratory Therapy	1,633,576			58,367				65
66	Physical Therapy	4,249,933			30,400				66
69	Electrocardiology	657,639			6,450				69
71	Medical Supplies Charged to Pat	2,071,455			109,412				71
72	Impl. Dev. Charged to Patients	557,187			52,671				72
73	Drugs Charged to Patients	5,501,151			203,418				73
76	CARDIAC REHAB	224,693							76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	5,799,187							88
88.01	RHC II	639,185							88.01
88.02	RHC III	942,710							88.02
90	Clinic	1,690,453			3,552				90
90.01	PAIN MANAGEMENT CLINIC								90.01
91	Emergency	6,303,202			57,734				91
92	Observation Beds (Non-Distinct	515,644			13,086				92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	80,137,654			2,102,140				200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1343** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.315276		2,844,116			896,682		50
52	Delivery Room & Labor Room	0.387787		22,335			8,661		52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.152632		3,930,330			599,894		54
54.01	RADIOLOGY-ULTRASOUND	0.122614		791,858			97,093		54.01
60	Laboratory	0.164299		2,802,410			460,433		60
62	Whole Blood & Packed Red Blood	0.416523							62
65	Respiratory Therapy	0.535697		171,965			92,121		65
66	Physical Therapy	0.538422		736,422			396,506		66
69	Electrocardiology	0.112995		200,994			22,711		69
71	Medical Supplies Charged to Pat	0.519873		311,482			161,931		71
72	Impl. Dev. Charged to Patients	0.651420		33,998			22,147		72
73	Drugs Charged to Patients	0.646127		745,093			481,425		73
76	CARDIAC REHAB	0.979648		1,254			1,228		76
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.243243		338,221			420,491		90
90.01	PAIN MANAGEMENT CLINIC								90.01
91	Emergency	0.404906		2,087,492			845,238		91
92	Observation Beds (Non-Distinct	1.094916		105,578			115,599		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			15,123,548			4,622,160		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			15,123,548			4,622,160		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,749	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,405	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)	2,939	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	229	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)	115	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,365	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)	229	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)	115	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	133.47	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	144.67	20
21	Total general inpatient routine service cost (see instructions)	4,542,139	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)	416,777	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,125,362	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,125,362	37

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Title XVIII, Part A [ ] Title XIX - I/P [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] PPS [ ] TEFRA [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)	1,211.56	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,653,779	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)	1,653,779	41

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

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,275,670	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,929,449	49

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)	277,447	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	139,329	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	416,776	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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					466	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,211.56	88
89	Observation bed cost (line 87 x line 88) (see instructions)					564,587	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	476,101	4,542,139	0.104819	564,587	59,179	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6150** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	[ ] Title V - I/P	[ ] Hospital	[ ] SUB (Other)	[ ] ICF/IID	[XX] PPS	
	[XX] Title XVIII, Part A	[ ] IPF	[XX] SNF		[ ] TEFRA	
	[ ] 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)	7,593	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,593	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)	7,593	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,152	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		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)	2,609,468	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 (line 21 minus line 26)	2,609,468	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,609,468	37

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-6150** **WORKSHEET D-1**
PARTS III & IV

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

PART III - SNF, NF, AND ICF/IID ONLY

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,609,468	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	343.67	71
72	Program routine service cost (line 9 x line 71)	395,908	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)	395,908	74
75	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26)		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)	395,908	83
84	Program inpatient ancillary services (see instructions)	261,845	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	657,753	86

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,749	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,405	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)	2,939	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	229	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)	115	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	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	484	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	369	15
16	Nursery days (title V or XIX only)	232	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	133.47	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	144.67	20
21	Total general inpatient routine service cost (see instructions)	4,542,139	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)	416,777	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,125,362	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,125,362	37

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,211.56	38
39	Program general inpatient routine service cost (line 9 x line 38)					586,395	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)					586,395	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)	177,894	369	482.10	232	111,847	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					746,686	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,444,928	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					70,527	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					79,304	51
52	Total Program excludable cost (sum of lines 50 and 51)					149,831	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					1,295,097	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1343** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					466	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1343** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,388,920		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.315276	512,131	161,463	50
52	Delivery Room & Labor Room	0.387787			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.152632	464,155	70,845	54
54.01	RADIOLOGY-ULTRASOUND	0.122614	185,665	22,765	54.01
60	Laboratory	0.164299	700,442	115,082	60
62	Whole Blood & Packed Red Blood Cells	0.416523	151,106	62,939	62
65	Respiratory Therapy	0.535697	302,097	161,832	65
66	Physical Therapy	0.538422	169,564	91,297	66
69	Electrocardiology	0.112995	57,385	6,484	69
71	Medical Supplies Charged to Patients	0.519873	402,354	209,173	71
72	Impl. Dev. Charged to Patients	0.651420	138,569	90,267	72
73	Drugs Charged to Patients	0.646127	406,062	262,368	73
76	CARDIAC REHAB	0.979648			76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.243243	16,314	20,282	90
90.01	PAIN MANAGEMENT CLINIC				90.01
91	Emergency	0.404906	2,156	873	91
92	Observation Beds (Non-Distinct Part)	1.094916			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,508,000	1,275,670	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,508,000		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z343** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.315276			50
52	Delivery Room & Labor Room	0.387787			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.152632	12,616	1,926	54
54.01	RADIOLOGY-ULTRASOUND	0.122614	1,044	128	54.01
60	Laboratory	0.164299	41,871	6,879	60
62	Whole Blood & Packed Red Blood Cells	0.416523	1,174	489	62
65	Respiratory Therapy	0.535697	60,851	32,598	65
66	Physical Therapy	0.538422	140,350	75,568	66
69	Electrocardiology	0.112995	508	57	69
71	Medical Supplies Charged to Patients	0.519873	37,272	19,377	71
72	Impl. Dev. Charged to Patients	0.651420			72
73	Drugs Charged to Patients	0.646127	55,196	35,664	73
76	CARDIAC REHAB	0.979648			76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.243243			90
90.01	PAIN MANAGEMENT CLINIC				90.01
91	Emergency	0.404906			91
92	Observation Beds (Non-Distinct Part)	1.094916			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		350,882	172,686	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		350,882		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-6150** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.315276			50
52	Delivery Room & Labor Room	0.387787			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.152632	17,257	2,634	54
54.01	RADIOLOGY-ULTRASOUND	0.122614	7,773	953	54.01
60	Laboratory	0.164299	36,106	5,932	60
62	Whole Blood & Packed Red Blood Cells	0.416523	2,207	919	62
65	Respiratory Therapy	0.535697	34,753	18,617	65
66	Physical Therapy	0.538422	401,348	216,095	66
69	Electrocardiology	0.112995	762	86	69
71	Medical Supplies Charged to Patients	0.519873	5,246	2,727	71
72	Impl. Dev. Charged to Patients	0.651420			72
73	Drugs Charged to Patients	0.646127	21,485	13,882	73
76	CARDIAC REHAB	0.979648			76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.243243			90
90.01	PAIN MANAGEMENT CLINIC				90.01
91	Emergency	0.404906			91
92	Observation Beds (Non-Distinct Part)	1.094916			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		526,937	261,845	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		526,937		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1343** **WORKSHEET D-3**

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		489,156		30
43	Nursery		237,864		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.315276	598,798	188,787	50
52	Delivery Room & Labor Room	0.387787	399,663	154,984	52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.152632	174,440	26,625	54
54.01	RADIOLOGY-ULTRASOUND	0.122614	37,871	4,644	54.01
60	Laboratory	0.164299	356,278	58,536	60
62	Whole Blood & Packed Red Blood Cells	0.416523			62
65	Respiratory Therapy	0.535697	58,367	31,267	65
66	Physical Therapy	0.538422	30,400	16,368	66
69	Electrocardiology	0.112995	6,450	729	69
71	Medical Supplies Charged to Patients	0.519873	109,412	56,880	71
72	Impl. Dev. Charged to Patients	0.651420	52,671	34,311	72
73	Drugs Charged to Patients	0.646127	203,418	131,434	73
76	CARDIAC REHAB	0.979648			76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.243243	3,552	4,416	90
90.01	PAIN MANAGEMENT CLINIC				90.01
91	Emergency	0.404906	57,734	23,377	91
92	Observation Beds (Non-Distinct Part)	1.094916	13,086	14,328	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,102,140	746,686	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,102,140		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1343** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	6,877,192			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	6,877,192			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	6,945,964			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	96,061			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,147,538			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,702,365			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)	3,702,365			30
31	Primary payer payments	1,115			31
32	Subtotal (line 30 minus line 31)	3,701,250			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	598,908			34
35	Adjusted reimbursable bad debts (see instructions)	389,290			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	427,529			36
37	Subtotal (see instructions)	4,090,540			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,090,540			40
40.01	Sequestration adjustment (see instructions)	81,811			40.01
41	Interim payments	4,353,530			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-344,801			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				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
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				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
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1343** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				2,228,786		4,353,530	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					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)				2,228,786		4,353,530	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		294,357			6.01
	based on the cost report (1)		.02				-344,801	6.02
7	Total Medicare program liability (see instructions)				2,523,143		4,008,729	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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z343** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				485,125			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					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)				485,125			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		91,309			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				576,434			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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-6150** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				346,684			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					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)				346,684			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due)		.01		290			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				346,974			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.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	850	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,365	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	2,939	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	85,829,750	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,882,352	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z343** **WORKSHEET E-2**

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	420,944		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	174,413		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	344		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	595,357		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	595,357		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	1,174		11
12	Subtotal (line 10 minus line 11)	594,183		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,985		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)	588,198		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	588,198		19
19.01	Sequestration adjustment (see instructions)	11,764		19.01
20	Interim payments	485,125		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	91,309		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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

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

1	Inpatient services	2,929,449	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,929,449	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,958,743	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,958,743	19
20	Deductibles (exclude professional component)	418,851	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,539,892	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	2,539,892	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,453	25
26	Adjusted reimbursable bad debts (see instructions)	34,744	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	30,361	27
28	Subtotal (sum of lines 24 and 26)	2,574,636	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,574,636	30
30.01	Sequestration adjustment (see instructions)	51,493	30.01
31	Interim payments	2,228,786	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	294,357	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §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	436,860	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	436,860	4
	COMPUTATION OF NET COST OF COVERED SERVICES		
5	Medical and other services. Do not use this line. (see instructions)		5
6	Deductibles		6
7	Coinsurance	83,101	7
8	Allowable bad debts (see instructions)	456	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)	296	10
11	Utilization review		11
12	Subtotal (sum of lines 4 and 5, minus lines 6 and 7, plus lines 10 and 11) (see instructions)	354,055	12
13	Inpatient primary payer payments		13
14	Other adjustments (specify) (see instructions)		14
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		14.50
15	Subtotal (see instructions)	354,055	15
15.01	Sequestration adjustment (see instructions)	7,081	15.01
16	Interim payments	346,684	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	290	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1343** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT-IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services		4,622,160	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		4,622,160	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		4,622,160	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges	727,020		8
9	Ancillary service charges	2,102,140	15,123,548	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)	2,829,160	15,123,548	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	2,829,160	15,123,548	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)		4,622,160	21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)		4,622,160	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4,622,160	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)		4,622,160	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		4,622,160	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)		4,622,160	40
41	Interim payments		4,622,160	41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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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	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	8,407,664				1
2	Temporary investments	953,217				2
3	Notes receivable					3
4	Accounts receivable	9,298,928				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-2,855,000				6
7	Inventory	1,066,154				7
8	Prepaid expenses	509,413				8
9	Other current assets	267,272				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	17,647,648				11
	FIXED ASSETS					
12	Land	340,645				12
13	Land improvements	1,146,066				13
14	Accumulated depreciation	-575,953				14
15	Buildings	50,141,439				15
16	Accumulated depreciation	-20,524,712				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,550,734				23
24	Accumulated depreciation	-8,798,446				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)	34,261,954				30
	OTHER ASSETS					
31	Investments	17,195,740				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	2,738,814				34
35	Total other assets (sum of lines 31-34)	19,934,554				35
36	Total assets (sum of lines 11, 30 and 35)	71,844,156				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,114,555				37
38	Salaries, wages and fees payable	2,556,437				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	927,317				40
41	Deferred income	10,266				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,216,169				44
45	Total current liabilities (sum of lines 37 thru 44)	5,824,744				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	13,136,924				47
48	Unsecured loans					48
49	Other long term liabilities	2,773,020				49
50	Total long term liabilities (sum of lines 46 thru 49)	15,909,944				50
51	Total liabilities (sum of lines 45 and 50)	21,734,688				51
	CAPITAL ACCOUNTS					
52	General fund balance	50,109,468				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	50,109,468				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	71,844,156				60

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		47,831,455			1
2	Net income (loss) (from Worksheet G-3, line 29)		2,278,013			2
3	Total (sum of line 1 and line 2)		50,109,468			3
4	Additions (credit adjustments) (specify)					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)		50,109,468			11
12	Deductions (debit adjustments) (specify)					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)		50,109,468			19

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	2,706,770		2,706,770	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	191,885		191,885	5
6	Swing Bed - NF				6
7	Skilled nursing facility	1,265,799		1,265,799	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	4,164,454		4,164,454	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	4,164,454		4,164,454	17
18	Ancillary services	10,867,676	56,045,521	66,913,197	18
19	Outpatient services		17,660,649	17,660,649	19
20	Rural Health Clinic (RHC)		6,382,462	6,382,462	20
20.01	RHC II		639,185	639,185	20.01
20.02	RHC III		359,435	359,435	20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		1,020,788	1,020,788	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN PRIVATE OFFICE		367,706	367,706	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	15,032,130	82,475,746	97,507,876	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		46,756,564	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)		46,756,564	43

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	97,507,876	1
2	Less contractual allowances and discounts on patients' accounts	49,792,742	2
3	Net patient revenues (line 1 minus line 2)	47,715,134	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	46,756,564	4
5	Net income from service to patients (line 3 minus line 4)	958,570	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	105,450	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	208,389	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients	11,791	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	206,195	22
23	Governmental appropriations	283,542	23
24	Other (CONSULTING CLINIC)	73,021	24
24.01	Other (WELLNESS)	59,111	24.01
24.02	Other (GRANTS)	13,550	24.02
24.03	Other (340B INCOME)	454	24.03
24.04	Other (FOUNDATION REIMBURSEMENT)		24.04
24.05	Other (DONATIONS)		24.05
24.06	Other (OTHER INCOME)	357,940	24.06
25	Total other income (sum of lines 6-24)	1,319,443	25
26	Total (line 5 plus line 25)	2,278,013	26
29	Net income (or loss) for the period (line 26 minus line 28)	2,278,013	29

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	112,613	7,320	421	25,767	47,094	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	290,788	19,071	18,850			6
7	Physical Therapy	48,432	3,148	6,124			7
8	Occupational Therapy	10,699	579	1,557			8
9	Speech Pathology	762		427			9
10	Medical Social Services						10
11	Home Health Aide	58,055	3,774	7,637			11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	521,349	33,892	35,016	25,767	47,094	24

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General	193,215	-13,215	180,000	-25,767	154,233	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	328,709		328,709		328,709	6
7	Physical Therapy	57,704		57,704		57,704	7
8	Occupational Therapy	12,835		12,835		12,835	8
9	Speech Pathology	1,189		1,189		1,189	9
10	Medical Social Services						10
11	Home Health Aide	69,466		69,466		69,466	11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)	663,118	-13,215	649,903	-25,767	624,136	24

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7175** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	154,233				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	328,709				6
7	Physical Therapy	57,704				7
8	Occupational Therapy	12,835				8
9	Speech Pathology	1,189				9
10	Medical Social Services					10
11	Home Health Aide	69,466				11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)	624,136				24

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General		154,233	154,233		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		328,709	107,890	436,599	6
7	Physical Therapy		57,704	18,940	76,644	7
8	Occupational Therapy		12,835	4,213	17,048	8
9	Speech Pathology		1,189	390	1,579	9
10	Medical Social Services					10
11	Home Health Aide		69,466	22,800	92,266	11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)		624,136		624,136	24

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-154,233	469,903	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						328,709	6
7	Physical Therapy						57,704	7
8	Occupational Therapy						12,835	8
9	Speech Pathology						1,189	9
10	Medical Social Services							10
11	Home Health Aide						69,466	11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)					-154,233	469,903	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						154,233	25
26	Unit Cost Multiplier						0.328223	26

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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 TELEPHONES	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
1	Administrative and General			658	22,829	839		1
2	Skilled Nursing Care	436,599			58,951			2
3	Physical Therapy	76,644			9,818			3
4	Occupational Therapy	17,048			2,169			4
5	Speech Pathology	1,579			154			5
6	Medical Social Services							6
7	Home Health Aide	92,266			11,769			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)	624,136		658	105,690	839		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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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	3,404		20,909	48,639	4,523		1
2	Skilled Nursing Care				495,550	46,079		2
3	Physical Therapy				86,462	8,040		3
4	Occupational Therapy				19,217	1,787		4
5	Speech Pathology				1,733	161		5
6	Medical Social Services							6
7	Home Health Aide				104,035	9,674		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)	3,404		20,909	755,636	70,264		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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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		2,756		13,654	79,902		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)		2,756		13,654	79,902		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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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 (cols 23 +/- 24)	
		15	16	17	24	25	26	
1	Administrative and General			2,000	151,474		151,474	1
2	Skilled Nursing Care				541,629		541,629	2
3	Physical Therapy				94,502		94,502	3
4	Occupational Therapy				21,004		21,004	4
5	Speech Pathology				1,894		1,894	5
6	Medical Social Services							6
7	Home Health Aide				113,709		113,709	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)			2,000	924,212		924,212	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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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 PtII)	TOTAL HHA COSTS					
		27	28					
1	Administrative and General							1
2	Skilled Nursing Care	106,173	647,802					2
3	Physical Therapy	18,524	113,026					3
4	Occupational Therapy	4,117	25,121					4
5	Speech Pathology	371	2,265					5
6	Medical Social Services							6
7	Home Health Aide	22,289	135,998					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)	151,474	924,212					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.	0.196022						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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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 TELEPHONES #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		796	112,613	9		11	1
2	Skilled Nursing Care			290,788				2
3	Physical Therapy			48,432				3
4	Occupational Therapy			10,699				4
5	Speech Pathology			762				5
6	Medical Social Services							6
7	Home Health Aide			58,055				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)		796	521,349	9		11	20
21	Total cost to be allocated		658	105,690	839		3,404	21
22	Unit Cost Multiplier			0.202724				22
22	Unit Cost Multiplier		0.826633		93.222222		309.454545	22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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		1,020,788		48,639			1
2	Skilled Nursing Care				495,550			2
3	Physical Therapy				86,462			3
4	Occupational Therapy				19,217			4
5	Speech Pathology				1,733			5
6	Medical Social Services							6
7	Home Health Aide				104,035			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)		1,020,788		755,636			20
21	Total cost to be allocated		20,909		70,264			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		0.020483		0.092987			22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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 ADMINIS-TRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY RX CSTD REQ'S	
		9	10	11	13	14	15	
1	Administrative and General	450		9	19,685			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		9	19,685			20
21	Total cost to be allocated	2,756		13,654	79,902			21
22	Unit Cost Multiplier	6.124444		1,517.111111				22
22	Unit Cost Multiplier				4.059030			22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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		2					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)		2					20
21	Total cost to be allocated		2,000					21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		1,000.000000					22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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	647,802		647,802	2,815	230.13	1
2	Physical Therapy	3	113,026		113,026	1,088	103.88	2
3	Occupational Therapy	4	25,121		25,121	231	108.75	3
4	Speech Pathology	5	2,265		2,265	52	43.56	4
5	Medical Social Services	6				1		5
6	Home Health Aide	7	135,998		135,998	580	234.48	6
7	Total (sum of lines 1-6)		924,212		924,212	4,767		7

Limitation Cost Comoputation

			Program Visits			
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	99914		2,020		8
9	Physical Therapy	99914		768		9
10	Occupational Therapy	99914		168		10
11	Speech Pathology	99914		36		11
12	Medical Social Services	99914		1		12
13	Home Health Aide	99914		495		13
14	Total (sum of lines 8-13)			3,488		14

Supplies and Drugs Cost 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 Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8		21,582	21,582	41,514	0.519873	15
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	
1	Physical Therapy	66	0.538422			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.519873	41,514	21,582	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.646127			col. 2, line 16	5

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		2,020			464,863		464,863	1
2	Physical Therapy		768			79,780		79,780	2
3	Occupational Therapy		168			18,270		18,270	3
4	Speech Pathology		36			1,568		1,568	4
5	Medical Social Services		1						5
6	Home Health Aide		495			116,068		116,068	6
7	Total (sum of lines 1-6)		3,488			680,549		680,549	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF HHA REIMBURSEMRNT 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

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	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 excced 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 amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		404,774	11
12	Total PPS Reimbursement - Full Episodes with Outliers		26,471	12
13	Total PPS Reimbursement - LUPA Episodes		9,190	13
14	Total PPS Reimbursement - PEP Episodes		3,898	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		10,221	15
16	Total PPS Outlier Reimbursement - PSP 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 thru 20 minus line 21)		454,554	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		454,554	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		454,554	26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)		454,554	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		454,554	31
31.01	Sequestration adjustment (see instructions)		9,091	31.01
32	Interim payments (see instructions)		445,463	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, §115-2			35

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES **HHA CCN: 14-7175** **WORKSHEET H-5**

				Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider						445,463	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					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	To	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		To	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)						445,463	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		To	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		To	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due)		.01					6.01
	based on the cost report (see instructions)		.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)						445,463	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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF CAPITAL PAYMENT **COMPONENT CCN: 14-1343** **WORKSHEET L**

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & 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
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & 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 Centers							201
202	TOTAL (sum of lines 118-201)							202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

COMPONENT CCN: 14-3429

WORKSHEET M-1

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

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	2,062,599		2,062,599		2,062,599	-185,099	1,877,500	1
2	Physician Assistant	64,298		64,298		64,298		64,298	2
3	Nurse Practitioner	19,167		19,167		19,167		19,167	3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	1,023,116	223,378	1,246,494	-45,273	1,201,221	-149,091	1,052,130	9
10	Subtotal (sum of lines 1 through 9)	3,169,180	223,378	3,392,558	-45,273	3,347,285	-334,190	3,013,095	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		227,630	227,630		227,630		227,630	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment				178,551	178,551		178,551	17
18	Professional Liability Insurance		171,602	171,602		171,602		171,602	18
19	Other Health Care Costs		61,242	61,242		61,242		61,242	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		460,474	460,474	178,551	639,025		639,025	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,169,180	683,852	3,853,032	133,278	3,986,310	-334,190	3,652,120	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		203,184	203,184	72,131	275,315		275,315	29
30	Administrative Costs	889,578	-161,693	727,885		727,885		727,885	30
31	Total Facility Overhead (sum of lines 29 and 30)	889,578	41,491	931,069	72,131	1,003,200		1,003,200	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	4,058,758	725,343	4,784,101	205,409	4,989,510	-334,190	4,655,320	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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3429** **WORKSHEET M-2**

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	5.39	26,068	4,200	22,638		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.80	2,084	2,100	3,780		3
4	Subtotal (sum of lines 1 through 3)	7.19	28,152		26,418	28,152	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	7.19	28,152			28,152	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	3,652,120	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	3,652,120	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	1,003,200	14
15	Parent provider overhead allocated to facility (see instructions)	1,576,134	15
16	Total overhead (sum of lines 14 and 15)	2,579,334	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	2,579,334	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	2,579,334	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	6,231,454	20

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3429** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	6,231,454	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	137,399	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	6,094,055	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	28,152	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	28,152	6
7	Adjusted cost per visit (line 3 divided by line 6)	216.47	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)	216.47	216.47	216.47	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		7,293		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,578,716		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		1,578,716		16
16.01	Total program charges (see instructions)(from contractor's records)		1,067,816		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		17,133		16.02
16.03	Total program preventive costs (see instructions)		25,330		16.03
16.04	Total program non-preventive costs (see instructions)		1,147,865		16.04
16.05	Total program cost (see instructions)		1,173,195		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		118,555		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		186,054		19
20	Net Medicare cost excluding vaccines (see instructions)		1,173,195		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		96,125		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,269,320		22
23	Allowable bad debts (see instructions)		50,085		23
23.01	Adjusted reimbursable bad debts (see instructions)		32,555		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		50,085		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,301,875		26
26.01	Sequestration adjustment (see instructions)		26,038		26.01
27	Interim payments		1,059,417		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		216,420		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3429** **WORKSHEET M-4**

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,013,095	3,013,095	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001624	0.002221	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	4,893	6,692	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	51,870	17,072	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	56,763	23,764	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	3,652,120	3,652,120	6
7	Total overhead (from Wkst. M-2, line 16)	2,579,334	2,579,334	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.015542	0.006507	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	40,088	16,784	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	96,851	40,548	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	780	1,067	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	124.17	38.00	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	630	471	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	78,227	17,898	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		137,399	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		96,125	16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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 I** **[ ] FQHC**

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				1,059,417	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				1,059,417	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		216,420	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				1,275,837	

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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

COMPONENT CCN: 14-3486

WORKSHEET M-1

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

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	3,048		3,048		3,048	-86	2,962	1
2	Physician Assistant								2
3	Nurse Practitioner	155,915		155,915		155,915		155,915	3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	117,309	19,610	136,919		136,919	-14,484	122,435	9
10	Subtotal (sum of lines 1 through 9)	276,272	19,610	295,882		295,882	-14,570	281,312	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		19,877	19,877		19,877		19,877	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		19,877	19,877		19,877		19,877	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	276,272	39,487	315,759		315,759	-14,570	301,189	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		28,662	28,662	7,581	36,243		36,243	29
30	Administrative Costs	33,490	129,863	163,353		163,353		163,353	30
31	Total Facility Overhead (sum of lines 29 and 30)	33,490	158,525	192,015	7,581	199,596		199,596	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	309,762	198,012	507,774	7,581	515,355	-14,570	500,785	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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3486** **WORKSHEET M-2**

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians			4,200			1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.80	4,717	2,100	1,680		3
4	Subtotal (sum of lines 1 through 3)	0.80	4,717		1,680	4,717	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	0.80	4,717			4,717	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	301,189	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	301,189	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	199,596	14
15	Parent provider overhead allocated to facility (see instructions)	128,283	15
16	Total overhead (sum of lines 14 and 15)	327,879	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	327,879	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	327,879	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	629,068	20

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3486** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	629,068	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	17,463	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	611,605	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	4,717	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	4,717	6
7	Adjusted cost per visit (line 3 divided by line 6)	129.66	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)	129.66	129.66	129.66	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		633		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		82,075		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		82,075		16
16.01	Total program charges (see instructions)(from contractor's records)		82,943		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,878		16.02
16.03	Total program preventive costs (see instructions)		3,837		16.03
16.04	Total program non-preventive costs (see instructions)		51,492		16.04
16.05	Total program cost (see instructions)		55,329		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		13,873		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		13,009		19
20	Net Medicare cost excluding vaccines (see instructions)		55,329		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,844		21
22	Total reimbursable Program cost (line 20 plus line 21)		66,173		22
23	Allowable bad debts (see instructions)		4,507		23
23.01	Adjusted reimbursable bad debts (see instructions)		2,930		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,507		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		69,103		26
26.01	Sequestration adjustment (see instructions)		1,382		26.01
27	Interim payments		48,706		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		19,015		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3486** **WORKSHEET M-4**

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	281,312	281,312	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001624	0.002221	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	457	625	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,655	2,624	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,112	3,249	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	301,189	301,189	6
7	Total overhead (from Wkst. M-2, line 16)	327,879	327,879	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016973	0.010787	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,565	3,537	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	10,677	6,786	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	70	164	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	152.53	41.38	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	54	63	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	8,237	2,607	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		17,463	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		10,844	16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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 II** **[ ] FQHC**

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				48,706	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				48,706	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		19,015	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				67,721	

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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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

COMPONENT CCN: 14-3488

WORKSHEET M-1

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

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	129,933		129,933		129,933	-5,692	124,241	1
2	Physician Assistant	12,115		12,115		12,115		12,115	2
3	Nurse Practitioner	139,858		139,858		139,858		139,858	3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	144,605	20,790	165,395	29,836	195,231		195,231	9
10	Subtotal (sum of lines 1 through 9)	426,511	20,790	447,301	29,836	477,137	-5,692	471,445	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		24,864	24,864		24,864		24,864	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		24,864	24,864		24,864		24,864	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	426,511	45,654	472,165	29,836	502,001	-5,692	496,309	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		34,894	34,894	66,127	101,021		101,021	29
30	Administrative Costs	33,072	107,792	140,864		140,864		140,864	30
31	Total Facility Overhead (sum of lines 29 and 30)	33,072	142,686	175,758	66,127	241,885		241,885	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	459,583	188,340	647,923	95,963	743,886	-5,692	738,194	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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3488** **WORKSHEET M-2**

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.31	2,146	4,200	5,502		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.18	4,102	2,100	378		3
4	Subtotal (sum of lines 1 through 3)	1.49	6,248		5,880	6,248	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.49	6,248			6,248	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	496,309	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	496,309	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	241,885	14
15	Parent provider overhead allocated to facility (see instructions)	190,045	15
16	Total overhead (sum of lines 14 and 15)	431,930	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	431,930	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	431,930	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	928,239	20

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3488** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	928,239	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	15,908	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	912,331	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	6,248	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	6,248	6
7	Adjusted cost per visit (line 3 divided by line 6)	146.02	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)	146.02	146.02	146.02	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		602		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		87,904		11
12	Program covered visits for mental health services (from contractor records)		44		12
13	Program covered cost from mental health services (line 9 x line 12)		6,425		13
14	Limit adjustment for mental health services (see instructions)		6,425		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		94,329		16
16.01	Total program charges (see instructions)(from contractor's records)		91,062		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,990		16.02
16.03	Total program preventive costs (see instructions)		6,205		16.03
16.04	Total program non-preventive costs (see instructions)		60,627		16.04
16.05	Total program cost (see instructions)		66,832		16.05
17	Primary payer payments		112		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		12,340		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		14,491		19
20	Net Medicare cost excluding vaccines (see instructions)		66,720		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,828		21
22	Total reimbursable Program cost (line 20 plus line 21)		72,548		22
23	Allowable bad debts (see instructions)		4,885		23
23.01	Adjusted reimbursable bad debts (see instructions)		3,175		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		4,885		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		75,723		26
26.01	Sequestration adjustment (see instructions)		1,514		26.01
27	Interim payments		66,204		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		8,005		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3488** **WORKSHEET M-4**

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	471,445	471,445	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001624	0.002221	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	766	1,047	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,261	4,432	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,027	5,479	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	496,309	496,309	6
7	Total overhead (from Wkst. M-2, line 16)	431,930	431,930	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006099	0.011039	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,634	4,768	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	5,661	10,247	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	34	277	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	166.50	36.99	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	29	27	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	4,829	999	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		15,908	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		5,828	16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2015 To: 04/30/2016	Run Date: 09/21/2016 Run Time: 16:11 Version: 2016.05 (09/08/2016)

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 III** **[ ] FQHC**

				Part B mm/dd/yyyy 1	Part B Amount 2	
	DESCRIPTION					
1	Total interim payments paid to provider				66,204	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				66,204	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due)		.01		8,005	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				74,209	

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.