CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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: 09/27/2018 Time: 07:56 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 CHIEF FINANCIAL 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 05/01/2017 and ending 04/30/2018, 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.

[_] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this cerficication statement to be the legally binding equivalent of my original signature.

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

CHIEF EXECUTIVE OFFICER
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		2,815	-89,892	1		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		20,665				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		1,244				7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			312,382			10
10.01	HEALTH CLINIC - RHC II			15,405			10.01
10.02	HEALTH CLINIC - RHC III			5,261			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		24,724	243,156	1		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.

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 / 2017	To: 04 / 30 / 2018	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
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)(i) or (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)(i) or (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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

Inpatient Psychiatric Faciltiy PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? 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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers		1	2	
105	Does this hospital qualify as a 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.	N	N	N	N	109

		1	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, compolete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110

		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-healsh services.	N		111

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 care related taxes as defined in §1983(w)(3) of the Act? 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 in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare cetfified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare cetfified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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 / 2017	04 / 30 / 2018	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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

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	08/23/2018	Y	08/23/2018	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: MARK	Last name: DALLAS	Title: PARTNER	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	9,125	59,928.00		1,096	412	2,497	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						359		366	5
6	Hospital Adults & Peds. Swing Bed NF								44	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	59,928.00		1,455	412	2,907	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						170	265	13
14	Total (see instructions)		25	9,125	59,928.00		1,455	582	3,172	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	35	12,775			1,870		7,039	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					2,819		3,451	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					6,808		28,944	26
26.01	RHC II	88.01					502		3,136	26.01
26.02	RHC III	88.02					685		5,367	26.02
27	Total (sum of lines 14-26)		60							27
28	Observation Bed Days							88	384	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							34	61	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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)					334	196	754	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)		275.66			334	196	754	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		22.89						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		8.20						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		48.72						26
26.01	RHC II		4.10						26.01
26.02	RHC III		5.03						26.02
27	Total (sum of lines 14-26)		364.60						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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		457		20	477	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)	1.01		1.01	4
5	Other Administrative Personnel	1.05		1.05	5
6	Direct Nursing Service	3.91		3.91	6
7	Nursing Supervisor				7
8	Physical Therapy Service	0.35		0.35	8
9	Physical Therapy Supervisor	0.37		0.37	9
10	Occupational Therapy Service	0.14		0.14	10
11	Occupational Therapy Supervisor	0.01		0.01	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	1.28		1.28	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	1,520	35		45	1,600	21
22	Skilled Nursing Visit Charges	328,320	7,560	5,184	9,720	350,784	22
23	Physical Therapy Visits	671		6	5	682	23
24	Physical Therapy Visit Charges	148,962		1,332	1,110	151,404	24
25	Occupational Therapy Visits	142		2	1	145	25
26	Occupational Therapy Visit Charges	31,524		444	222	32,190	26
27	Speech Pathology Visits	28				28	27
28	Speech Pathology Visit Charges	6,216				6,216	28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits	326		1	13	340	31
32	Home Health Aide Visit Charges	33,252		102	1,326	34,680	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,687	35	9	64	2,795	33
34	Other Charges	25,290	1,825	696	1,861	29,672	34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	573,564	9,385	7,758	14,239	604,946	35
36	Total Number of Episodes (standard/non-outlier)	171		12	4	187	36
37	Total Number of Ourlier Episodes		1			1	37
38	Total Non-Routine Medical Supply Charges	25,290	1,825	696	1,861	29,672	38

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA	12		12	14
15	RVC	37		37	15
16	RVB				16
17	RVA	55		55	17
18	RHC	236		236	18
19	RHB	149		149	19
20	RHA	683		683	20
21	RMC	166		166	21
22	RMB	43		43	22
23	RMA	185		185	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1	25		25	30
31	HD2				31
32	HD1	19		19	32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	29		29	36
37	LE2				37
38	LE1	9		9	38
39	LD2				39
40	LD1	18		18	40
41	LC2				41
42	LC1	24		24	42
43	LB2				43
44	LB1	29		29	44
45	CE2				45
46	CE1	24		24	46
47	CD2				47
48	CD1	13		13	48
49	CC2				49
50	CC1	10		10	50
51	CB2				51
52	CB1	35		35	52
53	CA2				53
54	CA1	5		5	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	1		1	66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

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	14		14	72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1	45		45	76
77	PA2				77
78	PA1	4		4	78
199	AAA				199
200	TOTAL	1,870		1,870	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	858,154	70.04%		202
203	Recruitment				203
204	Retention of employees				204
205	Training	1,675	0.14%		205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	1,225,306			207

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3429** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 1000 N ALLEN	1
2	City: ROBINSON State: IL ZIP Code: 62454 County: CRAWFORD	2
3	HOSPITAL-BASED 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 a hospital-based 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	RHC/FQHC 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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3486** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 209 EAST GRAND PRAIRIE	1
2	City: PALESTINE State: IL ZIP Code: 62451 County: CRAWFORD	2
3	HOSPITAL-BASED 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 a hospital-based 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	RHC/FQHC 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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3488** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 1000 N ALLEN	1
2	City: ROBINSON State: IL ZIP Code: 62454 County: CRAWFORD	2
3	HOSPITAL-BASED 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 a hospital-based 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	RHC/FQHC 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

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)	0.454482	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,172,952	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 and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	3,865,199	5
6	Medicaid charges	13,120,189	6
7	Medicaid cost (line 1 times line 6)	5,962,890	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.		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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,210,979	965,970	2,176,949	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	550,368	965,970	1,516,338	21
22	Payments received from patients for amounts previously written off as charity care	72,649	57,955	130,604	22
23	Cost of charity care (line 21 minus line 22)	477,719	908,015	1,385,734	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, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,145,438	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	368,467	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	566,872	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,578,566	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	915,835	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	2,301,569	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,301,569	31

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		2,376,771	2,376,771	55,109	2,431,880	-189,528	2,242,352	1
2	00200	Cap Rel Costs-Mvble Equip		1,022,137	1,022,137	5,457	1,027,594	-10,266	1,017,328	2
3	00300	Other Cap Rel Costs		27,576	27,576	-27,576			-0-	3
4	00400	Employee Benefits Department	242,571	3,595,868	3,838,439	1,523	3,839,962	-305,342	3,534,620	4
5.01	00540	NONPATIENT TELEPHONES		1,148	1,148	34,580	35,728		35,728	5.01
5.02	00550	DATA PROCESSING	240,650	895,989	1,136,639		1,136,639		1,136,639	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	161,713	33,265	194,978		194,978		194,978	5.03
5.04	00570	ADMITTING	394,030	91,757	485,787	-35,581	450,206		450,206	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	286,915	406,729	693,644		693,644		693,644	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	717,939	2,898,926	3,616,865		3,616,865	-250,741	3,366,124	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	556,025	999,241	1,555,266	37,055	1,592,321	-1,440	1,590,881	7
8	00800	Laundry & Linen Service	83,124	45,660	128,784		128,784		128,784	8
9	00900	Housekeeping	317,819	219,532	537,351		537,351		537,351	9
10	01000	Dietary	486,177	404,613	890,790	-487,392	403,398		403,398	10
11	01100	Cafeteria				487,392	487,392	-201,084	286,308	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	589,866	58,861	648,727		648,727		648,727	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	644,401	489,571	1,133,972		1,133,972	-29,323	1,104,649	15
16	01600	Medical Records & Library	416,626	126,741	543,367		543,367	-3,984	539,383	16
17	01700	Social Service	53,588	4,257	57,845		57,845		57,845	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	2,785,506	514,028	3,299,534	-207,786	3,091,748	-1,049,041	2,042,707	30
43	04300	Nursery				70,435	70,435		70,435	43
44	04400	Skilled Nursing Facility	953,537	218,778	1,172,315	159,560	1,331,875		1,331,875	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	913,780	440,163	1,353,943	930,403	2,284,346	-832,353	1,451,993	50
52	05200	Delivery Room & Labor Room				137,351	137,351		137,351	52
53	05300	Anesthesiology	832,353	98,050	930,403	-930,403				53
54	05400	Radiology-Diagnostic	681,835	603,791	1,285,626	-11,961	1,273,665	-400	1,273,265	54
54.01	05401	RADIOLOGY-ULTRASOUND	21,764	194,570	216,334		216,334		216,334	54.01
60	06000	Laboratory	624,023	1,061,911	1,685,934	-75,406	1,610,528		1,610,528	60
62	06200	Whole Blood & Packed Red Blood Cells				75,406	75,406		75,406	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	436,117	154,831	590,948		590,948	-30,560	560,388	65
66	06600	Physical Therapy	1,094,748	146,389	1,241,137	-8,419	1,232,718		1,232,718	66
69	06900	Electrocardiology	20,600	3,336	23,936		23,936		23,936	69
71	07100	Medical Supplies Charged to Patients		462,579	462,579		462,579		462,579	71
72	07200	Impl. Dev. Charged to Patients		-7,029	-7,029		-7,029	37,500	30,471	72
73	07300	Drugs Charged to Patients		1,578,122	1,578,122	11,961	1,590,083		1,590,083	73
76	03950	CARDIAC REHAB	23,849	7,944	31,793		31,793		31,793	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	3,885,582	807,632	4,693,214	220,368	4,913,582	-81,358	4,832,224	88
88.01	08801	RHC II	254,593	93,939	348,532	6,791	355,323	-9,299	346,024	88.01
88.02	08802	RHC III	401,388	80,473	481,861	76,764	558,625	-3,650	554,975	88.02
90	09000	Clinic	2,137,441	876,946	3,014,387	12,087	3,026,474	-2,110,102	916,372	90
90.01	09001	PAIN MANAGEMENT CLINIC	167,241	43,801	211,042		211,042		211,042	90.01
91	09100	Emergency	811,539	1,909,887	2,721,426		2,721,426	-1,304,917	1,416,509	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	469,193	99,360	568,553	13,058	581,611	-10,451	571,160	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		500,478	500,478	-500,478				113
118		SUBTOTALS (sum of lines 1-117)	21,706,533	23,588,621	45,295,154	50,298	45,345,452	-6,386,339	38,959,113	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	71,415	146,861	218,276	13,246	231,522		231,522	192
192.10	19201	PHYSICIAN HOSPITALIST								192.10
194	07950	NONREIMBURSEABLE								194
194.01	07951	PROFESSIONAL BUILDINGS		180,511	180,511	-63,622	116,889		116,889	194.01
194.02	07952	FOUNDATION SERVICES	27,882	6,554	34,436		34,436		34,436	194.02
194.03	07953	WELLNESS	86,838	18,572	105,410	78	105,488		105,488	194.03

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	
194.04	07954	RENTED SPACE								194.04
194.05	07955	LITIGATION COSTS								194.05
200		TOTAL (sum of lines 118-199)	21,892,668	23,941,119	45,833,787		45,833,787	-6,386,339	39,447,448	200

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES			
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	LTC ADMITTING COSTS	A	Skilled Nursing Facility	44	810	191	1
500	Total reclassifications				810	191	500
	Code Letter - A						
1	CAFETERIA COSTS	B	Cafeteria	11	265,618	221,774	1
500	Total reclassifications				265,618	221,774	500
	Code Letter - B						
1	COST OF BLOOD	C	Whole Blood & Packed Red Bloo	62		75,406	1
500	Total reclassifications					75,406	500
	Code Letter - C						
1	PBX COSTS	E	NONPATIENT TELEPHONES	5.01	27,971	6,609	1
500	Total reclassifications				27,971	6,609	500
	Code Letter - E						
1	DEP PROF BLDGS	F	PROFESSIONAL BUILDINGS	194.01		38,687	1
2			Rural Health Clinic	88		164,846	2
3			RHC II	88.01		6,791	3
4			RHC III	88.02		66,283	4
5			Clinic	90		17,663	5
6			Home Health Agency	101		13,058	6
7			WELLNESS	194.03		1,601	7
500	Total reclassifications					308,929	500
	Code Letter - F						
1	SNF	G	Skilled Nursing Facility	44		158,559	1
500	Total reclassifications					158,559	500
	Code Letter - G						
1	LABOR/DEL & NB COSTS	H	Nursery	43	59,683	10,752	1
2			Delivery Room & Labor Room	52	116,385	20,966	2
500	Total reclassifications				176,068	31,718	500
	Code Letter - H						
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	I	Drugs Charged to Patients	73		11,961	1
500	Total reclassifications					11,961	500
	Code Letter - I						
1	OR COST	J	Operating Room	50	832,353	98,050	1
500	Total reclassifications				832,353	98,050	500
	Code Letter - J						
1	R/C PALESTINE OBLONG DRS	K	Physicians' Private Offices	192		13,246	1
2			RHC III	88.02		10,481	2
500	Total reclassifications					23,727	500
	Code Letter - K						
1	HEALTHWORKS COSTS	L	Employee Benefits Department	4	1,257	266	1
500	Total reclassifications				1,257	266	500
	Code Letter - L						
1	UTILITIES	M	Operation of Plant	7		37,055	1
2							2
500	Total reclassifications					37,055	500
	Code Letter - M						
1	INTEREST EXPENSE	N	Cap Rel Costs-Bldg & Fixt	1		500,478	1
500	Total reclassifications					500,478	500
	Code Letter - N						
1	UTILITIES & MAINTENANCE	O	Rural Health Clinic	88		79,249	1
500	Total reclassifications					79,249	500
	Code Letter - O						
1	PROPERTY TAX PT	P	Physical Therapy	66		23,060	1
500	Total reclassifications					23,060	500
	Code Letter - P						
	GRAND TOTAL (Increases)				1,304,077	1,577,032	

(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.

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	LTC ADMITTING COSTS	A	ADMITTING	5.04	810	191		1
500	Total reclassifications				810	191		500
	Code letter - A							
1	CAFETERIA COSTS	B	Dietary	10	265,618	221,774		1
500	Total reclassifications				265,618	221,774		500
	Code letter - B							
1	COST OF BLOOD	C	Laboratory	60		75,406		1
500	Total reclassifications					75,406		500
	Code letter - C							
1	PBX COSTS	E	ADMITTING	5.04	27,971	6,609		1
500	Total reclassifications				27,971	6,609		500
	Code letter - E							
1	DEP PROF BLDGS	F	Cap Rel Costs-Bldg & Fixt	1		308,929	9	1
2							9	2
3							9	3
4							9	4
5							9	5
6							9	6
7							9	7
500	Total reclassifications					308,929		500
	Code letter - F							
1	SNF	G	Cap Rel Costs-Bldg & Fixt	1		158,559	9	1
500	Total reclassifications					158,559		500
	Code letter - G							
1	LABOR/DEL & NB COSTS	H	Adults & Pediatrics	30	176,068	31,718		1
2								2
500	Total reclassifications				176,068	31,718		500
	Code letter - H							
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	I	Radiology-Diagnostic	54		11,961		1
500	Total reclassifications					11,961		500
	Code letter - I							
1	OR COST	J	Anesthesiology	53	832,353	98,050		1
500	Total reclassifications				832,353	98,050		500
	Code letter - J							
1	R/C PALESTINE OBLONG DRS	K	Rural Health Clinic	88		23,727		1
2								2
500	Total reclassifications					23,727		500
	Code letter - K							
1	HEALTHWORKS COSTS	L	WELLNESS	194.03	1,257	266		1
500	Total reclassifications				1,257	266		500
	Code letter - L							
1	UTILITIES	M	Physical Therapy	66		31,479		1
2			Clinic	90		5,576		2
500	Total reclassifications					37,055		500
	Code letter - M							
1	INTEREST EXPENSE	N	Interest Expense	113		500,478	11	1
500	Total reclassifications					500,478		500
	Code letter - N							
1	UTILITIES & MAINTENANCE	O	PROFESSIONAL BUILDINGS	194.01		79,249		1
500	Total reclassifications					79,249		500
	Code letter - O							
1	PROPERTY TAX PT	P	PROFESSIONAL BUILDINGS	194.01		23,060		1
500	Total reclassifications					23,060		500
	Code letter - P							
	GRAND TOTAL (Decreases)				1,304,077	1,577,032		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	490,645					490,645		1
2	Land Improvements	1,115,487					1,115,487		2
3	Buildings and Fixtures	53,468,370	1,936,306		1,936,306	660,500	54,744,176		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	13,586,849	1,448,058		1,448,058	1,074,333	13,960,574		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	68,661,351	3,384,364		3,384,364	1,734,833	70,310,882		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	68,661,351	3,384,364		3,384,364	1,734,833	70,310,882		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	2,376,771						2,376,771	1
2	Cap Rel Costs-Mvble Equip	1,022,137						1,022,137	2
3	Total (sum of lines 1-2)	3,398,908						3,398,908	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	55,074,502		55,074,502	0.802118			22,119	22,119	1
2	Cap Rel Costs-Mvble Equ	13,586,849		13,586,849	0.197882			5,457	5,457	2
3	Total (sum of lines 1-2)	68,661,351		68,661,351	1.000000			27,576	27,576	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	1,909,283	-194,421	505,371			22,119	2,242,352	1
2	Cap Rel Costs-Mvble Equip	1,011,871					5,457	1,017,328	2
3	Total (sum of lines 1-2)	2,921,154	-194,421	505,371			27,576	3,259,680	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)	B	-194,421	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	-4,567,481				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	-201,084	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	-3,984	Medical Records & Library	16		18
19	Nursing and allied health education (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	-10,266	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYS RECRUITING	A	-84,701	OTHER ADMINISTRATIVE AND GENERAL	5.06		33
33.11	EMPLOYEE INJURY	A	-5,653	Employee Benefits Department	4		33.11
33.22	EMPLOYEE PHYSICIALS	A	-845	Employee Benefits Department	4		33.22
34	ADVERTISING	A	-121,058	OTHER ADMINISTRATIVE AND GENERAL	5.06		34
35	TV ADMINISTRATION	A	-7,205	OTHER ADMINISTRATIVE AND GENERAL	5.06		35
36	TV UTILITIES & REPAIR	A	-1,440	Operation of Plant	7		36
37							37
38	EMPLOYEE DISCOUNTS	A	-39,392	Employee Benefits Department	4		38
39							39
40	EMPLOYEE SALES - PHARMACY	B	-29,323	Pharmacy	15		40
41							41
42	CONSULTING CLINIC	B	-89,524	Clinic	90		42
42.11	OTHER INCOME ROBINSON RHC	B	-40,458	Rural Health Clinic	88		42.11
43							43
44	OTHER INCOME PALESTINE	B	-9,299	RHC II	88.01		44
45							45
46							46
47							47
48	HOSPITALIST BENEFITS	A	-175,841	Adults & Pediatrics	30		48
48.15	PHYSICIAN BENEFITS	A	-259,452	Employee Benefits Department	4		48.15
48.25	OTHER A&G	A	-49,492	OTHER ADMINISTRATIVE AND GENERAL	5.06		48.25
48.75	BOND ISSUE COSTS	A	20,208	Cap Rel Costs-Bldg & Fixt	1	11	48.75
48.80	2012 BOND INT NON-DED	A	-15,315	Cap Rel Costs-Bldg & Fixt	1	11	48.80
49	DME	A	-53	Adults & Pediatrics	30		49
49.01	NONALLOW CARELINK COST	A	-10,451	Home Health Agency	101		49.01
49.02	MISC INCOME	B	-25,658	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.02
49.03	AHA & IHA DUES	A	-13,099	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.03
49.04	OB LOCUM TENUMS	A	-18,000	Adults & Pediatrics	30		49.04
49.05	NONPATIENT CPR	B	-1,700	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.05
49.07	DONATIONS, PROJECTS	B	-11,479	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.07
49.13	ADMIN CLAIMS FEES	A	63,651	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.13
49.15	PHYSICIAN FEES	B	-520,624	Clinic	90		49.15
49.16	IMPLANT INVEN ADJ	A	37,500	Impl. Dev. Charged to Patients	72		49.16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	
49.20	MRI RENT	B	-400	Radiology-Diagnostic	54		49.20
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-6,386,339				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.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	90.01	PAIN MANAGEMENT CLINIC	SALARIES	167,241	167,241			1
2	90.01	PAIN MANAGEMENT CLINIC	OTHER EXPENSES	43,801	43,801			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			211,042	211,042			5

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

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

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

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

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6	B			CRAWFORD MEM HOSP PAIN MGMT LL	51.00	PAIN MANAGEMENT SERVICES	6
7							7
8							8
9							9
10							10

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

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

PROVIDER-BASED 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	30,560	30,560						1
2	91	Emergency AGGREGATE	1,729,512	1,304,917	424,595					2
3	30	Adults & Pediatrics HOSPITALIST	855,147	855,147						3
4	90	Clinic AGGREGATE	1,499,954	1,499,954						4
5	88	Rural Health Clinic AGGREGATE	40,900	40,900						5
6	88.02	RHC III AGGREGATE	3,650	3,650						6
7										7
8	50	Operating Room AGGREGATE	832,353	832,353						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	4,992,076	4,567,481	424,595					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							30,560	1
2	91	Emergency AGGREGATE							1,304,917	2
3	30	Adults & Pediatrics HOSPITALIST							855,147	3
4	90	Clinic AGGREGATE							1,499,954	4
5	88	Rural Health Clinic AGGREGATE							40,900	5
6	88.02	RHC III AGGREGATE							3,650	6
7										7
8	50	Operating Room AGGREGATE							832,353	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							4,567,481	200

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	Overtime 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

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	2,242,352	2,242,352					1
2	Cap Rel Costs-Mvble Equip	1,017,328		1,017,328				2
4	Employee Benefits Department	3,534,620	16,333	1,638	3,552,591			4
5.01	NONPATIENT TELEPHONES	35,728			5,405	41,133		5.01
5.02	DATA PROCESSING	1,136,639	15,673	275,860	46,498	3,226	1,477,896	5.02
5.03	PURCHASING RECEIVING AND STORES	194,978	41,701	4,416	31,246	807		5.03
5.04	ADMITTING	450,206	13,787	2,066	70,573	1,613		5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	693,644	22,803	3,156	55,438	1,344	931,518	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	3,366,124	169,747	8,370	138,720	2,420	546,378	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,590,881	155,129	60,714	107,435	1,075		7
8	Laundry & Linen Service	128,784	47,887	3,033	16,061	134		8
9	Housekeeping	537,351	15,617	2,478	61,409	134		9
10	Dietary	403,398	63,183	14,970	42,616	941		10
11	Cafeteria	286,308	37,080		51,323			11
12	Maintenance of Personnel							12
13	Nursing Administration	648,727	19,936		113,974	807		13
14	Central Services & Supply							14
15	Pharmacy	1,104,649	23,915	35,123	124,511	1,344		15
16	Medical Records & Library	539,383	58,619	10,596	80,500	2,151		16
17	Social Service	57,845	943	240	10,354	269		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,042,707	201,301	70,142	338,964	7,392		30
43	Nursery	70,435	7,865		11,532	269		43
44	Skilled Nursing Facility	1,331,875		12,030	184,399	3,764		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,451,993	371,840	161,716	176,561	3,495		50
52	Delivery Room & Labor Room	137,351	23,595		22,488			52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,273,265	64,070	166,978	131,744	2,151		54
54.01	RADIOLOGY-ULTRASOUND	216,334	9,147	2,156	4,205			54.01
60	Laboratory	1,610,528	32,214	20,993	120,574	1,075		60
62	Whole Blood & Packed Red Blood Cells	75,406	2,075					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	560,388	21,690	22,813	78,362	807		65
66	Physical Therapy	1,232,718	189,041	8,709	211,527	941		66
69	Electrocardiology	23,936	5,130		3,980	269		69
71	Medical Supplies Charged to Patients	462,579	28,574					71
72	Impl. Dev. Charged to Patients	30,471	9,977					72
73	Drugs Charged to Patients	1,590,083						73
76	CARDIAC REHAB	31,793	43,342	11,483	4,608	269		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,832,224		15,772	742,865	672		88
88.01	RHC II	346,024		1,232	48,487	807		88.01
88.02	RHC III	554,975		9,575	77,556	269		88.02
90	Clinic	916,372	254,884	21,433	123,175	269		90
90.01	PAIN MANAGEMENT CLINIC	211,042	14,221	3,615	32,314			90.01
91	Emergency	1,416,509	181,063	39,115	156,806	269		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	571,160		1,649	90,659	1,210		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	38,959,113	2,162,382	992,071	3,516,869	40,193	1,477,896	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		13,203					190
192	Physicians' Private Offices	231,522		4,064	13,799			192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	116,889				672		194.01
194.02	FOUNDATION SERVICES	34,436	943		5,387	134		194.02
194.03	WELLNESS	105,488	65,824	21,193	16,536	134		194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	39,447,448	2,242,352	1,017,328	3,552,591	41,133	1,477,896	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	273,148						5.03
5.04	ADMITTING	757	539,002					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	282		1,708,185				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	2,167			4,233,926	4,233,926		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	4,494			1,919,728	230,820	2,150,548	7
8	Laundry & Linen Service	2,945			198,844	23,908	50,944	8
9	Housekeeping	6,483			623,472	74,964	16,613	9
10	Dietary	4,827			529,935	63,717	67,216	10
11	Cafeteria				374,711	45,054	39,447	11
12	Maintenance of Personnel							12
13	Nursing Administration	427			783,871	94,250	21,208	13
14	Central Services & Supply							14
15	Pharmacy	113,225			1,402,767	168,663	25,442	15
16	Medical Records & Library	756			692,005	83,204	62,360	16
17	Social Service	15			69,666	8,376	1,003	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,077	125,095	64,690	2,859,368	343,799	223,759	30
43	Nursery		16,244	8,400	114,745	13,796	8,367	43
44	Skilled Nursing Facility	3,900			1,535,968	184,679	218,422	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,088	74,898	277,894	2,537,485	305,097	395,569	50
52	Delivery Room & Labor Room		44,481	23,003	250,918	30,169	25,101	52
53	Anesthesiology							53
54	Radiology-Diagnostic	7,489	42,004	369,004	2,056,705	247,290	68,159	54
54.01	RADIOLOGY-ULTRASOUND		8,826	66,305	306,973	36,909	9,731	54.01
60	Laboratory	28,183	60,796	369,987	2,244,350	269,852	34,270	60
62	Whole Blood & Packed Red Blood Cells		6,330	8,103	91,914	11,051	2,207	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,704	20,414	34,487	741,665	89,175	23,074	65
66	Physical Therapy	1,228	45,443	94,497	1,784,104	214,514	201,106	66
69	Electrocardiology		2,637	13,864	49,816	5,990	5,458	69
71	Medical Supplies Charged to Patients	23,416	29,077	28,764	572,410	68,824	30,398	71
72	Impl. Dev. Charged to Patients	9,564	759	6,095	56,866	6,837	10,614	72
73	Drugs Charged to Patients		52,797	139,941	1,782,821	214,359		73
76	CARDIAC REHAB	181	1	4,397	96,074	11,552	46,108	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	17,378			5,608,911	674,388		88
88.01	RHC II	1,537			398,087	47,864		88.01
88.02	RHC III	2,069			644,444	77,485		88.02
90	Clinic	4,278		32,374	1,352,785	162,653	271,151	90
90.01	PAIN MANAGEMENT CLINIC	57		5,162	266,411	32,032	15,129	90.01
91	Emergency	5,001	9,200	144,239	1,952,202	234,725	192,619	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	814		16,979	682,471	82,058		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	272,342	539,002	1,708,185	38,816,418	4,158,054	2,065,475	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				13,203	1,587	14,045	190
192	Physicians' Private Offices	115			249,500	29,999		192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	92			117,653	14,146		194.01
194.02	FOUNDATION SERVICES	6			40,906	4,918	1,003	194.02
194.03	WELLNESS	593			209,768	25,222	70,025	194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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	
202	TOTAL (sum of lines 118-201)	273,148	539,002	1,708,185	39,447,448	4,233,926	2,150,548	202

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	273,696						8
9	Housekeeping		715,049					9
10	Dietary	3,967	19,235	684,070				10
11	Cafeteria		11,288		470,500			11
12	Maintenance of Personnel							12
13	Nursing Administration		6,069		32,826	938,224		13
14	Central Services & Supply							14
15	Pharmacy		7,281		17,507	60,964	1,682,624	15
16	Medical Records & Library		17,846		24,072			16
17	Social Service		287		2,188	8,234		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	83,785	64,033	206,482	67,842	243,860		30
43	Nursery	1,066	2,394		4,377	15,763		43
44	Skilled Nursing Facility	71,351	62,505	432,940	50,333	179,582		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	38,105	113,198	22,316	41,579	146,226		50
52	Delivery Room & Labor Room	799	7,183		8,753	29,829		52
53	Anesthesiology							53
54	Radiology-Diagnostic	15,283	19,505		26,260			54
54.01	RADIOLOGY-ULTRASOUND		2,785					54.01
60	Laboratory	207	9,807		26,260			60
62	Whole Blood & Packed Red Blood Cells		632					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,754	6,603		17,507	62,106		65
66	Physical Therapy		57,550		37,202			66
69	Electrocardiology		1,562					69
71	Medical Supplies Charged to Patients		8,699					71
72	Impl. Dev. Charged to Patients		3,037					72
73	Drugs Charged to Patients						1,682,624	73
76	CARDIAC REHAB		13,195					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,223	104,920					88
88.01	RHC II	140						88.01
88.02	RHC III	167						88.02
90	Clinic	2,712	77,595		28,449			90
90.01	PAIN MANAGEMENT CLINIC		4,329		8,753			90.01
91	Emergency	48,772	55,121	22,332	35,014	126,525		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,584		17,507	65,135		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	272,331	679,243	684,070	446,429	938,224	1,682,624	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,019					190
192	Physicians' Private Offices				6,565			192
192.10	PHYSICIAN HOSPITALIST				8,753			192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		11,461					194.01
194.02	FOUNDATION SERVICES		287		2,188			194.02
194.03	WELLNESS	1,365	20,039		6,565			194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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	
202	TOTAL (sum of lines 118-201)	273,696	715,049	684,070	470,500	938,224	1,682,624	202

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	879,487						16
17	Social Service		89,754					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	34,297	60,135	4,187,360		4,187,360		30
43	Nursery	4,454		164,962		164,962		43
44	Skilled Nursing Facility		26,926	2,762,706		2,762,706		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	147,333		3,746,908		3,746,908		50
52	Delivery Room & Labor Room	12,196		364,948		364,948		52
53	Anesthesiology							53
54	Radiology-Diagnostic	195,637		2,628,839		2,628,839		54
54.01	RADIOLOGY-ULTRASOUND	35,153		391,551		391,551		54.01
60	Laboratory	196,172		2,780,918		2,780,918		60
62	Whole Blood & Packed Red Blood Cells	4,296		110,100		110,100		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,284		960,168		960,168		65
66	Physical Therapy	50,100		2,344,576		2,344,576		66
69	Electrocardiology	7,350		70,176		70,176		69
71	Medical Supplies Charged to Patients	15,250		695,581		695,581		71
72	Impl. Dev. Charged to Patients	3,232		80,586		80,586		72
73	Drugs Charged to Patients	74,193		3,753,997		3,753,997		73
76	CARDIAC REHAB	2,331		169,260		169,260		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			6,392,442		6,392,442		88
88.01	RHC II			446,091		446,091		88.01
88.02	RHC III			722,096		722,096		88.02
90	Clinic			1,895,345		1,895,345		90
90.01	PAIN MANAGEMENT CLINIC	2,737		329,391		329,391		90.01
91	Emergency	76,472	1,795	2,745,577		2,745,577		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		898	850,653		850,653		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	879,487	89,754	38,594,231		38,594,231		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			32,854		32,854		190
192	Physicians' Private Offices			286,064		286,064		192
192.10	PHYSICIAN HOSPITALIST			8,753		8,753		192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS			143,260		143,260		194.01
194.02	FOUNDATION SERVICES			49,302		49,302		194.02
194.03	WELLNESS			332,984		332,984		194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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		
202	TOTAL (sum of lines 118-201)	879,487	89,754	39,447,448		39,447,448		202

	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		16,333	1,638	17,971	17,971		4
5.01	NONPATIENT TELEPHONES					27	27	5.01
5.02	DATA PROCESSING		15,673	275,860	291,533	235	2	5.02
5.03	PURCHASING RECEIVING AND STORES		41,701	4,416	46,117	158	1	5.03
5.04	ADMITTING		13,787	2,066	15,853	357	1	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		22,803	3,156	25,959	280	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		169,747	8,370	178,117	701	2	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		155,129	60,714	215,843	543	1	7
8	Laundry & Linen Service		47,887	3,033	50,920	81		8
9	Housekeeping		15,617	2,478	18,095	311		9
10	Dietary		63,183	14,970	78,153	215	1	10
11	Cafeteria		37,080		37,080	260		11
12	Maintenance of Personnel							12
13	Nursing Administration		19,936		19,936	576	1	13
14	Central Services & Supply							14
15	Pharmacy		23,915	35,123	59,038	630	1	15
16	Medical Records & Library		58,619	10,596	69,215	407	1	16
17	Social Service		943	240	1,183	52		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,497	201,301	70,142	286,940	1,714	5	30
43	Nursery		7,865		7,865	58		43
44	Skilled Nursing Facility	10,516		12,030	22,546	932	2	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	50,155	371,840	161,716	583,711	893	2	50
52	Delivery Room & Labor Room		23,595		23,595	114		52
53	Anesthesiology							53
54	Radiology-Diagnostic		64,070	166,978	231,048	666	1	54
54.01	RADIOLOGY-ULTRASOUND		9,147	2,156	11,303	21		54.01
60	Laboratory		32,214	20,993	53,207	610	1	60
62	Whole Blood & Packed Red Blood Cells		2,075		2,075			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		21,690	22,813	44,503	396	1	65
66	Physical Therapy		189,041	8,709	197,750	1,070	1	66
69	Electrocardiology		5,130		5,130	20		69
71	Medical Supplies Charged to Patients		28,574		28,574			71
72	Impl. Dev. Charged to Patients		9,977		9,977			72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB		43,342	11,483	54,825	23		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			15,772	15,772	3,766		88
88.01	RHC II			1,232	1,232	245	1	88.01
88.02	RHC III	12,600		9,575	22,175	392		88.02
90	Clinic		254,884	21,433	276,317	623		90
90.01	PAIN MANAGEMENT CLINIC		14,221	3,615	17,836	163		90.01
91	Emergency		181,063	39,115	220,178	793		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			1,649	1,649	458	1	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	88,768	2,162,382	992,071	3,243,221	17,790	27	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		13,203		13,203			190
192	Physicians' Private Offices	1,500		4,064	5,564	70		192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS							194.01
194.02	FOUNDATION SERVICES		943		943	27		194.02
194.03	WELLNESS		65,824	21,193	87,017	84		194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	
		0	1	2	2A	4	5.01	
202	TOTAL (sum of lines 118-201)	90,268	2,242,352	1,017,328	3,349,948	17,971	27	202

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	291,770						5.02
5.03	PURCHASING RECEIVING AND STORES		46,276					5.03
5.04	ADMITTING		128	16,339				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	183,903	48		210,191			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	107,867	367			287,054		5.06
6	Maintenance & Repairs							6
7	Operation of Plant		761			15,650	232,798	7
8	Laundry & Linen Service		499			1,621	5,515	8
9	Housekeeping		1,098			5,083	1,798	9
10	Dietary		818			4,320	7,276	10
11	Cafeteria					3,055	4,270	11
12	Maintenance of Personnel							12
13	Nursing Administration		72			6,390	2,296	13
14	Central Services & Supply							14
15	Pharmacy		19,181			11,435	2,754	15
16	Medical Records & Library		128			5,641	6,751	16
17	Social Service		3			568	109	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,538	3,787	7,960	23,310	24,222	30
43	Nursery			493	1,034	935	906	43
44	Skilled Nursing Facility		661			12,521	23,644	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		3,234	2,271	34,192	20,686	42,820	50
52	Delivery Room & Labor Room			1,349	2,830	2,045	2,717	52
53	Anesthesiology							53
54	Radiology-Diagnostic		1,269	1,274	45,403	16,766	7,378	54
54.01	RADIOLOGY-ULTRASOUND			268	8,158	2,502	1,053	54.01
60	Laboratory		4,775	1,843	45,539	18,296	3,710	60
62	Whole Blood & Packed Red Blood Cells			192	997	749	239	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		458	619	4,243	6,046	2,498	65
66	Physical Therapy		208	1,378	11,627	14,544	21,770	66
69	Electrocardiology			80	1,706	406	591	69
71	Medical Supplies Charged to Patients		3,967	882	3,539	4,666	3,291	71
72	Impl. Dev. Charged to Patients		1,620	23	750	464	1,149	72
73	Drugs Charged to Patients			1,601	17,218	14,534		73
76	CARDIAC REHAB		31		541	783	4,991	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		2,944			45,717		88
88.01	RHC II		260			3,245		88.01
88.02	RHC III		351			5,254		88.02
90	Clinic		725		3,983	11,028	29,352	90
90.01	PAIN MANAGEMENT CLINIC		10		635	2,172	1,638	90.01
91	Emergency		847	279	17,747	15,914	20,851	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		138		2,089	5,564		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	291,770	46,139	16,339	210,191	281,910	223,589	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					108	1,520	190
192	Physicians' Private Offices		19			2,034		192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		16			959		194.01
194.02	FOUNDATION SERVICES		1			333	109	194.02
194.03	WELLNESS		101			1,710	7,580	194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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	
202	TOTAL (sum of lines 118-201)	291,770	46,276	16,339	210,191	287,054	232,798	202

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	58,636						8
9	Housekeeping		26,385					9
10	Dietary	850	710	92,343				10
11	Cafeteria		417		45,082			11
12	Maintenance of Personnel							12
13	Nursing Administration		224		3,145	32,640		13
14	Central Services & Supply							14
15	Pharmacy		269		1,677	2,121	97,106	15
16	Medical Records & Library		658		2,307			16
17	Social Service		11		210	286		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17,950	2,363	27,873	6,500	8,483		30
43	Nursery	228	88		419	548		43
44	Skilled Nursing Facility	15,286	2,306	58,443	4,823	6,248		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,164	4,175	3,012	3,984	5,087		50
52	Delivery Room & Labor Room	171	265		839	1,038		52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,274	720		2,516			54
54.01	RADIOLOGY-ULTRASOUND		103					54.01
60	Laboratory	44	362		2,516			60
62	Whole Blood & Packed Red Blood Cells		23					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	376	244		1,677	2,161		65
66	Physical Therapy		2,124		3,565			66
69	Electrocardiology		58					69
71	Medical Supplies Charged to Patients		321					71
72	Impl. Dev. Charged to Patients		112					72
73	Drugs Charged to Patients						97,106	73
76	CARDIAC REHAB		487					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	905	3,872					88
88.01	RHC II	30						88.01
88.02	RHC III	36						88.02
90	Clinic	581	2,863		2,726			90
90.01	PAIN MANAGEMENT CLINIC		160		839			90.01
91	Emergency	10,449	2,034	3,015	3,355	4,402		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		95		1,677	2,266		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	58,344	25,064	92,343	42,775	32,640	97,106	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		148					190
192	Physicians' Private Offices				629			192
192.10	PHYSICIAN HOSPITALIST				839			192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		423					194.01
194.02	FOUNDATION SERVICES		11		210			194.02
194.03	WELLNESS	292	739		629			194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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	
202	TOTAL (sum of lines 118-201)	58,636	26,385	92,343	45,082	32,640	97,106	202

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	85,108						16
17	Social Service		2,422					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,319	1,623	417,587		417,587		30
43	Nursery	431		13,005		13,005		43
44	Skilled Nursing Facility		727	148,139		148,139		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	14,256		726,487		726,487		50
52	Delivery Room & Labor Room	1,180		36,143		36,143		52
53	Anesthesiology							53
54	Radiology-Diagnostic	18,930		329,245		329,245		54
54.01	RADIOLOGY-ULTRASOUND	3,401		26,809		26,809		54.01
60	Laboratory	18,989		149,892		149,892		60
62	Whole Blood & Packed Red Blood Cells	416		4,691		4,691		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,769		64,991		64,991		65
66	Physical Therapy	4,848		258,885		258,885		66
69	Electrocardiology	711		8,702		8,702		69
71	Medical Supplies Charged to Patients	1,476		46,716		46,716		71
72	Impl. Dev. Charged to Patients	313		14,408		14,408		72
73	Drugs Charged to Patients	7,179		137,638		137,638		73
76	CARDIAC REHAB	226		61,907		61,907		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			72,976		72,976		88
88.01	RHC II			5,013		5,013		88.01
88.02	RHC III			28,208		28,208		88.02
90	Clinic			328,198		328,198		90
90.01	PAIN MANAGEMENT CLINIC	265		23,718		23,718		90.01
91	Emergency	7,399	48	307,311		307,311		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		24	13,961		13,961		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	85,108	2,422	3,224,630		3,224,630		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			14,979		14,979		190
192	Physicians' Private Offices			8,316		8,316		192
192.10	PHYSICIAN HOSPITALIST			839		839		192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS			1,398		1,398		194.01
194.02	FOUNDATION SERVICES			1,634		1,634		194.02
194.03	WELLNESS			98,152		98,152		194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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		
202	TOTAL (sum of lines 118-201)	85,108	2,422	3,349,948		3,349,948		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	118,890						1
2	Cap Rel Costs-Mvble Equip		1,130,604					2
4	Employee Benefits Department	866	1,820	18,386,282				4
5.01	NONPATIENT TELEPHONES			27,971	306			5.01
5.02	DATA PROCESSING	831	306,573	240,650	24	10,000		5.02
5.03	PURCHASING RECEIVING AND STORES	2,211	4,908	161,713	6		3,772,912	5.03
5.04	ADMITTING	731	2,296	365,249	12		10,462	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,209	3,507	286,915	10	6,303	3,900	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,000	9,302	717,939	18	3,697	29,931	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	8,225	67,474	556,025	8		62,077	7
8	Laundry & Linen Service	2,539	3,371	83,124	1		40,680	8
9	Housekeeping	828	2,754	317,819	1		89,548	9
10	Dietary	3,350	16,637	220,559	7		66,669	10
11	Cafeteria	1,966		265,618				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,057		589,866	6		5,898	13
14	Central Services & Supply							14
15	Pharmacy	1,268	39,034	644,401	10		1,563,935	15
16	Medical Records & Library	3,108	11,776	416,626	16		10,438	16
17	Social Service	50	267	53,588	2		213	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	10,673	77,952	1,754,291	55		125,373	30
43	Nursery	417		59,683	2			43
44	Skilled Nursing Facility		13,370	954,347	28		53,865	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,715	179,723	913,780	26		263,657	50
52	Delivery Room & Labor Room	1,251		116,385				52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397	185,571	681,835	16		103,449	54
54.01	RADIOLOGY-ULTRASOUND	485	2,396	21,764				54.01
60	Laboratory	1,708	23,330	624,023	8		389,290	60
62	Whole Blood & Packed Red Blood Cells	110						62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,150	25,353	405,557	6		37,347	65
66	Physical Therapy	10,023	9,679	1,094,748	7		16,956	66
69	Electrocardiology	272		20,600	2			69
71	Medical Supplies Charged to Patients	1,515					323,441	71
72	Impl. Dev. Charged to Patients	529					132,109	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	2,298	12,762	23,849	2		2,495	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		17,528	3,844,682	5		240,032	88
88.01	RHC II		1,369	250,943	6		21,231	88.01
88.02	RHC III		10,641	401,388	2		28,578	88.02
90	Clinic	13,514	23,820	637,487	2		59,092	90
90.01	PAIN MANAGEMENT CLINIC	754	4,018	167,241			787	90.01
91	Emergency	9,600	43,470	811,539	2		69,082	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,833	469,199	9		11,250	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	114,650	1,102,534	18,201,404	299	10,000	3,761,785	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices		4,517	71,415			1,583	192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				5		1,267	194.01
194.02	FOUNDATION SERVICES	50		27,882	1		80	194.02
194.03	WELLNESS	3,490	23,553	85,581	1		8,197	194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross foot adjustments							200
201	Negative cost centers							201

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	
202	Cost to be allocated (Per Wkst. B, Part I)	2,242,352	1,017,328	3,552,591	41,133	1,477,896	273,148	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.860728	0.899809	0.193220	134.421569	147.789600	0.072397	203
204	Cost to be allocated (Per Wkst. B, Part II)			17,971	27	291,770	46,276	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000977	0.088235	29.177000	0.012265	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	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	12,305,714						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		75,413,374					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-4,233,926	35,213,522			5.06
6	Maintenance & Repairs							6
7	Operation of Plant				1,919,728	107,182		7
8	Laundry & Linen Service				198,844	2,539	191,461	8
9	Housekeeping				623,472	828		9
10	Dietary				529,935	3,350	2,775	10
11	Cafeteria				374,711	1,966		11
12	Maintenance of Personnel							12
13	Nursing Administration				783,871	1,057		13
14	Central Services & Supply							14
15	Pharmacy				1,402,767	1,268		15
16	Medical Records & Library				692,005	3,108		16
17	Social Service				69,666	50		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,855,960	2,855,960		2,859,368	11,152	58,610	30
43	Nursery	370,865	370,860		114,745	417	746	43
44	Skilled Nursing Facility				1,535,968	10,886	49,913	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,709,972	12,268,507		2,537,485	19,715	26,656	50
52	Delivery Room & Labor Room	1,015,533	1,015,533		250,918	1,251	559	52
53	Anesthesiology							53
54	Radiology-Diagnostic	958,979	16,290,842		2,056,705	3,397	10,691	54
54.01	RADIOLOGY-ULTRASOUND	201,500	2,927,238		306,973	485		54.01
60	Laboratory	1,387,998	16,334,395		2,244,350	1,708	145	60
62	Whole Blood & Packed Red Blood Cells	144,518	357,738		91,914	110		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	466,061	1,522,518		741,665	1,150	1,227	65
66	Physical Therapy	1,037,486	4,171,882		1,784,104	10,023		66
69	Electrocardiology	60,205	612,066		49,816	272		69
71	Medical Supplies Charged to Patients	663,850	1,269,862		572,410	1,515		71
72	Impl. Dev. Charged to Patients	17,326	269,096		56,866	529		72
73	Drugs Charged to Patients	1,205,391	6,178,126		1,782,821			73
76	CARDIAC REHAB	34	194,111		96,074	2,298		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				5,608,911		2,954	88
88.01	RHC II				398,087		98	88.01
88.02	RHC III				644,444		117	88.02
90	Clinic		1,429,240		1,352,785	13,514	1,897	90
90.01	PAIN MANAGEMENT CLINIC		227,906		266,411	754		90.01
91	Emergency	210,036	6,367,882		1,952,202	9,600	34,118	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		749,612		682,471			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	12,305,714	75,413,374	-4,233,926	34,582,492	102,942	190,506	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				13,203	700		190
192	Physicians' Private Offices				249,500			192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				117,653			194.01
194.02	FOUNDATION SERVICES				40,906	50		194.02
194.03	WELLNESS				209,768	3,490	955	194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross foot adjustments							200
201	Negative cost centers							201

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	
202	Cost to be allocated (Per Wkst. B, Part I)	539,002	1,708,185		4,233,926	2,150,548	273,696	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.043801	0.022651		0.120236	20.064451	1.429513	203
204	Cost to be allocated (Per Wkst. B, Part II)	16,339	210,191		287,054	232,798	58,636	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.001328	0.002787		0.008152	2.171988	0.306256	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

	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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	124,534						9
10	Dietary	3,350	42,088					10
11	Cafeteria	1,966		215				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,057		15	248,732			13
14	Central Services & Supply							14
15	Pharmacy	1,268		8	16,162	629,031		15
16	Medical Records & Library	3,108		11			73,234,527	16
17	Social Service	50		1	2,183			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,152	12,704	31	64,649		2,855,960	30
43	Nursery	417		2	4,179		370,865	43
44	Skilled Nursing Facility	10,886	26,637	23	47,609			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,715	1,373	19	38,766		12,268,507	50
52	Delivery Room & Labor Room	1,251		4	7,908		1,015,533	52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397		12			16,290,842	54
54.01	RADIOLOGY-ULTRASOUND	485					2,927,238	54.01
60	Laboratory	1,708		12			16,334,395	60
62	Whole Blood & Packed Red Blood Cells	110					357,738	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,150		8	16,465		1,522,518	65
66	Physical Therapy	10,023		17			4,171,882	66
69	Electrocardiology	272					612,066	69
71	Medical Supplies Charged to Patients	1,515					1,269,862	71
72	Impl. Dev. Charged to Patients	529					269,096	72
73	Drugs Charged to Patients					629,031	6,178,126	73
76	CARDIAC REHAB	2,298					194,111	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	18,273						88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic	13,514		13				90
90.01	PAIN MANAGEMENT CLINIC	754		4			227,906	90.01
91	Emergency	9,600	1,374	16	33,543		6,367,882	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	450		8	17,268			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	118,298	42,088	204	248,732	629,031	73,234,527	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices			3				192
192.10	PHYSICIAN HOSPITALIST			4				192.10
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
194.05	LITIGATION COSTS							194.05
200	Cross foot adjustments							200
201	Negative cost centers							201

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	
202	Cost to be allocated (Per Wkst. B, Part I)	715,049	684,070	470,500	938,224	1,682,624	879,487	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5.741797	16.253326	2,188.372093	3.772028	2.674946	0.012009	203
204	Cost to be allocated (Per Wkst. B, Part II)	26,385	92,343	45,082	32,640	97,106	85,108	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.211870	2.194046	209.683721	0.131226	0.154374	0.001162	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	100						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	67						30
43	Nursery							43
44	Skilled Nursing Facility	30						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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency	2						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1						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
192.10	PHYSICIAN HOSPITALIST							192.10
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
194.05	LITIGATION COSTS							194.05

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME						
		17						
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	89,754						202
203	Unit Cost Multiplier (Wkst. B, Part I)	897.540000						203
204	Cost to be allocated (Per Wkst. B, Part II)	2,422						204
205	Unit Cost Multiplier (Wkst. B, Part II)	24.220000						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	4,187,360		4,187,360		4,187,360	30
43	Nursery	164,962		164,962		164,962	43
44	Skilled Nursing Facility	2,762,706		2,762,706		2,762,706	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,746,908		3,746,908		3,746,908	50
52	Delivery Room & Labor Room	364,948		364,948		364,948	52
53	Anesthesiology						53
54	Radiology-Diagnostic	2,628,839		2,628,839		2,628,839	54
54.01	RADIOLOGY-ULTRASOUND	391,551		391,551		391,551	54.01
60	Laboratory	2,780,918		2,780,918		2,780,918	60
62	Whole Blood & Packed Red Blood Cells	110,100		110,100		110,100	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	960,168		960,168		960,168	65
66	Physical Therapy	2,344,576		2,344,576		2,344,576	66
69	Electrocardiology	70,176		70,176		70,176	69
71	Medical Supplies Charged to Patients	695,581		695,581		695,581	71
72	Impl. Dev. Charged to Patients	80,586		80,586		80,586	72
73	Drugs Charged to Patients	3,753,997		3,753,997		3,753,997	73
76	CARDIAC REHAB	169,260		169,260		169,260	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	6,392,442		6,392,442		6,392,442	88
88.01	RHC II	446,091		446,091		446,091	88.01
88.02	RHC III	722,096		722,096		722,096	88.02
90	Clinic	1,895,345		1,895,345		1,895,345	90
90.01	PAIN MANAGEMENT CLINIC	329,391		329,391		329,391	90.01
91	Emergency	2,745,577		2,745,577		2,745,577	91
92	Observation Beds (Non-Distinct Part)	494,450		494,450		494,450	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	850,653		850,653		850,653	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	39,088,681		39,088,681		39,088,681	200
201	Less Observation Beds	494,450		494,450		494,450	201
202	Total (line 200 minus line 201)	38,594,231		38,594,231		38,594,231	202

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	2,855,960		2,855,960				30
43	Nursery	370,865		370,865				43
44	Skilled Nursing Facility	1,222,863		1,222,863				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,709,972	10,558,535	12,268,507	0.305409	0.305409	0.305409	50
52	Delivery Room & Labor Room	1,015,533		1,015,533	0.359366	0.359366	0.359366	52
53	Anesthesiology							53
54	Radiology-Diagnostic	958,979	15,331,863	16,290,842	0.161369	0.161369	0.161369	54
54.01	RADIOLOGY-ULTRASOUND	201,500	2,725,738	2,927,238	0.133761	0.133761	0.133761	54.01
60	Laboratory	1,387,998	14,946,397	16,334,395	0.170249	0.170249	0.170249	60
62	Whole Blood & Packed Red Blood Cells	144,518	213,220	357,738	0.307767	0.307767	0.307767	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	466,061	1,056,457	1,522,518	0.630645	0.630645	0.630645	65
66	Physical Therapy	1,037,486	3,134,396	4,171,882	0.561995	0.561995	0.561995	66
69	Electrocardiology	62,205	549,861	612,066	0.114654	0.114654	0.114654	69
71	Medical Supplies Charged to Patients	663,850	606,012	1,269,862	0.547761	0.547761	0.547761	71
72	Impl. Dev. Charged to Patients	17,326	251,770	269,096	0.299469	0.299469	0.299469	72
73	Drugs Charged to Patients	1,205,391	4,972,735	6,178,126	0.607627	0.607627	0.607627	73
76	CARDIAC REHAB	34	194,077	194,111	0.871975	0.871975	0.871975	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		6,434,348	6,434,348				88
88.01	RHC II		486,791	486,791				88.01
88.02	RHC III		886,369	886,369				88.02
90	Clinic	118,710	1,313,161	1,431,871	1.323684	1.323684	1.323684	90
90.01	PAIN MANAGEMENT CLINIC		227,906	227,906	1.445293	1.445293	1.445293	90.01
91	Emergency	210,036	6,157,846	6,367,882	0.431160	0.431160	0.431160	91
92	Observation Beds (Non-Distinct Part)		472,851	472,851	1.045678	1.045678	1.045678	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		749,612	749,612				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	13,649,287	71,269,945	84,919,232				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	13,649,287	71,269,945	84,919,232				202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **WORKSHEET C PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,187,360		4,187,360		4,187,360	30
43	Nursery	164,962		164,962		164,962	43
44	Skilled Nursing Facility	2,762,706		2,762,706		2,762,706	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,746,908		3,746,908		3,746,908	50
52	Delivery Room & Labor Room	364,948		364,948		364,948	52
53	Anesthesiology						53
54	Radiology-Diagnostic	2,628,839		2,628,839		2,628,839	54
54.01	RADIOLOGY-ULTRASOUND	391,551		391,551		391,551	54.01
60	Laboratory	2,780,918		2,780,918		2,780,918	60
62	Whole Blood & Packed Red Blood Cells	110,100		110,100		110,100	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	960,168		960,168		960,168	65
66	Physical Therapy	2,344,576		2,344,576		2,344,576	66
69	Electrocardiology	70,176		70,176		70,176	69
71	Medical Supplies Charged to Patients	695,581		695,581		695,581	71
72	Impl. Dev. Charged to Patients	80,586		80,586		80,586	72
73	Drugs Charged to Patients	3,753,997		3,753,997		3,753,997	73
76	CARDIAC REHAB	169,260		169,260		169,260	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	6,392,442		6,392,442		6,392,442	88
88.01	RHC II	446,091		446,091		446,091	88.01
88.02	RHC III	722,096		722,096		722,096	88.02
90	Clinic	1,895,345		1,895,345		1,895,345	90
90.01	PAIN MANAGEMENT CLINIC	329,391		329,391		329,391	90.01
91	Emergency	2,745,577		2,745,577		2,745,577	91
92	Observation Beds (Non-Distinct Part)	494,450		494,450		494,450	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	850,653		850,653		850,653	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	39,088,681		39,088,681		39,088,681	200
201	Less Observation Beds	494,450		494,450		494,450	201
202	Total (line 200 minus line 201)	38,594,231		38,594,231		38,594,231	202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET) **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							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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
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
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	3,746,908	726,487	3,020,421		50
52	Delivery Room & Labor Room	364,948	36,143	328,805		52
53	Anesthesiology					53
54	Radiology-Diagnostic	2,628,839	329,245	2,299,594		54
54.01	RADIOLOGY-ULTRASOUND	391,551	26,809	364,742		54.01
60	Laboratory	2,780,918	149,892	2,631,026		60
62	Whole Blood & Packed Red Blood Cells	110,100	4,691	105,409		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	960,168	64,991	895,177		65
66	Physical Therapy	2,344,576	258,885	2,085,691		66
69	Electrocardiology	70,176	8,702	61,474		69
71	Medical Supplies Charged to Patients	695,581	46,716	648,865		71
72	Impl. Dev. Charged to Patients	80,586	14,408	66,178		72
73	Drugs Charged to Patients	3,753,997	137,638	3,616,359		73
76	CARDIAC REHAB	169,260	61,907	107,353		76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	6,392,442	72,976	6,319,466		88
88.01	RHC II	446,091	5,013	441,078		88.01
88.02	RHC III	722,096	28,208	693,888		88.02
90	Clinic	1,895,345	328,198	1,567,147		90
90.01	PAIN MANAGEMENT CLINIC	329,391	23,718	305,673		90.01
91	Emergency	2,745,577	307,311	2,438,266		91
92	Observation Beds (Non-Distinct Part)	494,450	49,310	445,140		92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	850,653	13,961	836,692		101
113	Interest Expense					113
200	Subtotal	31,973,653	2,695,209	29,278,444		200
201	Less Observation Beds	494,450	49,310	445,140		201
202	Total	31,479,203	2,645,899	28,833,304		202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY **WORKSHEET C PART II**

[ ] Title V **[XX] Title XIX**

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		3,746,908			50
52	Delivery Room & Labor Room		364,948			52
53	Anesthesiology					53
54	Radiology-Diagnostic		2,628,839			54
54.01	RADIOLOGY-ULTRASOUND		391,551			54.01
60	Laboratory		2,780,918			60
62	Whole Blood & Packed Red Blood Cells		110,100			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		960,168			65
66	Physical Therapy		2,344,576			66
69	Electrocardiology		70,176			69
71	Medical Supplies Charged to Patients		695,581			71
72	Impl. Dev. Charged to Patients		80,586			72
73	Drugs Charged to Patients		3,753,997			73
76	CARDIAC REHAB		169,260			76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic		6,392,442			88
88.01	RHC II		446,091			88.01
88.02	RHC III		722,096			88.02
90	Clinic		1,895,345			90
90.01	PAIN MANAGEMENT CLINIC		329,391			90.01
91	Emergency		2,745,577			91
92	Observation Beds (Non-Distinct Part)		494,450	472,851	1.045678	92
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		850,653			101
113	Interest Expense					113
200	Subtotal		31,973,653	472,851		200
201	Less Observation Beds		494,450	472,851		201
202	Total		31,479,203			202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed 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	0.305409		2,967,906			906,425		50
52	Delivery Room & Labor Room	0.359366							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.161369		5,420,842			874,756		54
54.01	RADIOLOGY-ULTRASOUND	0.133761		837,196			111,984		54.01
60	Laboratory	0.170249		6,466,075			1,100,843		60
62	Whole Blood & Packed Red Blood	0.307767		128,093			39,423		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.630645		428,308			270,110		65
66	Physical Therapy	0.561995		1,039,366			584,118		66
69	Electrocardiology	0.114654		342,589			39,279		69
71	Medical Supplies Charged to Pat	0.547761		130,928			71,717		71
72	Impl. Dev. Charged to Patients	0.299469		172,238			51,580		72
73	Drugs Charged to Patients	0.607627		1,772,094			1,076,772		73
76	CARDIAC REHAB	0.871975		41,884			36,522		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.323684		1,046,177			1,384,808		90
90.01	PAIN MANAGEMENT CLINIC	1.445293							90.01
91	Emergency	0.431160		1,864,685			803,978		91
92	Observation Beds (Non-Distinct	1.045678		246,700			257,969		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			22,905,081			7,610,284		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			22,905,081			7,610,284		202

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P**
[ ] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[XX] Swing Bed SNF **[ ] Swing Bed 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	0.305409							50
52	Delivery Room & Labor Room	0.359366							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.161369							54
54.01	RADIOLOGY-ULTRASOUND	0.133761							54.01
60	Laboratory	0.170249							60
62	Whole Blood & Packed Red Blood	0.307767							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.630645							65
66	Physical Therapy	0.561995							66
69	Electrocardiology	0.114654							69
71	Medical Supplies Charged to Pat	0.547761							71
72	Impl. Dev. Charged to Patients	0.299469							72
73	Drugs Charged to Patients	0.607627							73
76	CARDIAC REHAB	0.871975							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.323684							90
90.01	PAIN MANAGEMENT CLINIC	1.445293							90.01
91	Emergency	0.431160							91
92	Observation Beds (Non-Distinct	1.045678							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

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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76	CARDIAC REHAB									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
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: 14-6150** | **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	12,268,507							50
52	Delivery Room & Labor Room	1,015,533							52
53	Anesthesiology								53
54	Radiology-Diagnostic	16,290,842			10,235				54
54.01	RADIOLOGY-ULTRASOUND	2,927,238			1,326				54.01
60	Laboratory	16,334,395			70,022				60
62	Whole Blood & Packed Red Blood	357,738			14,048				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,522,518			23,944				65
66	Physical Therapy	4,171,882			681,410				66
69	Electrocardiology	612,066			5,717				69
71	Medical Supplies Charged to Pat	1,269,862			7,968				71
72	Impl. Dev. Charged to Patients	269,096							72
73	Drugs Charged to Patients	6,178,126			48,295				73
76	CARDIAC REHAB	194,111							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	6,434,348							88
88.01	RHC II	486,791							88.01
88.02	RHC III	886,369							88.02
90	Clinic	1,431,871							90
90.01	PAIN MANAGEMENT CLINIC	227,906							90.01
91	Emergency	6,367,882			7,226				91
92	Observation Beds (Non-Distinct	472,851							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	79,719,932			870,191				200

(A) Worksheet A line numbers

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	0.305409							50
52	Delivery Room & Labor Room	0.359366							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.161369							54
54.01	RADIOLOGY-ULTRASOUND	0.133761							54.01
60	Laboratory	0.170249							60
62	Whole Blood & Packed Red Blood	0.307767							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.630645							65
66	Physical Therapy	0.561995							66
69	Electrocardiology	0.114654							69
71	Medical Supplies Charged to Pat	0.547761							71
72	Impl. Dev. Charged to Patients	0.299469							72
73	Drugs Charged to Patients	0.607627							73
76	CARDIAC REHAB	0.871975							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.323684							90
90.01	PAIN MANAGEMENT CLINIC	1.445293							90.01
91	Emergency	0.431160							91
92	Observation Beds (Non-Distinct	1.045678							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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	417,587	47,637	369,950	2,881	128.41	412	52,905	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	13,005		13,005	265	49.08	170	8,344	43
44	Skilled Nursing Facility	148,139		148,139	7,039	21.05			44
45	Nursing Facility								45
200	Total (lines 30-199)	578,731		531,094	10,185		582	61,249	200

(A) Worksheet A line numbers

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	726,487	12,268,507	0.059216			50
52	Delivery Room & Labor Room	36,143	1,015,533	0.035590			52
53	Anesthesiology						53
54	Radiology-Diagnostic	329,245	16,290,842	0.020210			54
54.01	RADIOLOGY-ULTRASOUND	26,809	2,927,238	0.009158			54.01
60	Laboratory	149,892	16,334,395	0.009176			60
62	Whole Blood & Packed Red Blood	4,691	357,738	0.013113			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	64,991	1,522,518	0.042687			65
66	Physical Therapy	258,885	4,171,882	0.062055			66
69	Electrocardiology	8,702	612,066	0.014217			69
71	Medical Supplies Charged to Pat	46,716	1,269,862	0.036788			71
72	Impl. Dev. Charged to Patients	14,408	269,096	0.053542			72
73	Drugs Charged to Patients	137,638	6,178,126	0.022278			73
76	CARDIAC REHAB	61,907	194,111	0.318926			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	72,976	6,434,348	0.011342			88
88.01	RHC II	5,013	486,791	0.010298			88.01
88.02	RHC III	28,208	886,369	0.031824			88.02
90	Clinic	328,198	1,431,871	0.229209			90
90.01	PAIN MANAGEMENT CLINIC	23,718	227,906	0.104069			90.01
91	Emergency	307,311	6,367,882	0.048260			91
92	Observation Beds (Non-Distinct	49,310	472,851	0.104282			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,681,248	79,719,932				200

(A) Worksheet A line numbers

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 Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	1A	1	2A	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

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)	2,881		412		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	265		170		43
44	Skilled Nursing Facility	7,039				44
45	Nursing Facility					45
200	Total (lines 30-199)	10,185		582		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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	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	2A	2	3A	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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76	CARDIAC REHAB									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
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

		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								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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
76	CARDIAC REHAB								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
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 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								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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
76	CARDIAC REHAB								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
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	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,291	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,881	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)	2,497	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	244	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)	122	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	29	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)	15	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,096	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)	239	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)	120	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	144.67	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	4,187,360	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)	4,195	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,213	25
26	Total swing-bed cost (see instructions)	477,684	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,709,676	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)	3,709,676	37

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)					1,287.64	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,411,253	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)					1,411,253	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)					1,363,566	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,774,819	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)	307,746	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	154,517	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	462,263	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

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)					384	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,287.63	88
89	Observation bed cost (line 87 x line 88) (see instructions)					494,450	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	417,587	4,187,360	0.099726	494,450	49,310	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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)	7,039	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,039	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)	7,039	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)	1,870	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)	2,762,706	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)	2,762,706	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)	2,762,706	37

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)	2,762,706	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	392.49	71
72	Program routine service cost (line 9 x line 71)	733,956	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)	733,956	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)	733,956	83
84	Program inpatient ancillary services (see instructions)	453,604	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	1,187,560	86

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)	3,291	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,881	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)	2,497	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	244	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)	122	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	29	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)	15	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	412	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)	265	15
16	Nursery days (title V or XIX only)	170	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	144.67	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	4,187,360	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)	4,195	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,213	25
26	Total swing-bed cost (see instructions)	477,684	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,709,676	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)	3,709,676	37

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)	1,287.64	38
39	Program general inpatient routine service cost (line 9 x line 38)	530,508	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)	530,508	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)	164,962	265	622.50	170	105,825	42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

		1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	636,333	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	61,249	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)	61,249	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	575,084	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

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)					384	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,287.63	88
89	Observation bed cost (line 87 x line 88) (see instructions)					494,450	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	417,587	4,187,360	0.099726	494,450	49,310	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

Check	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] 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		1,277,938		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.305409	423,298	129,279	50
52	Delivery Room & Labor Room	0.359366			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.161369	642,147	103,623	54
54.01	RADIOLOGY-ULTRASOUND	0.133761	116,744	15,616	54.01
60	Laboratory	0.170249	749,927	127,674	60
62	Whole Blood & Packed Red Blood Cells	0.307767	80,541	24,788	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.630645	298,337	188,145	65
66	Physical Therapy	0.561995	135,162	75,960	66
69	Electrocardiology	0.114654	55,930	6,413	69
71	Medical Supplies Charged to Patients	0.547761	359,879	197,128	71
72	Impl. Dev. Charged to Patients	0.299469	15,839	4,743	72
73	Drugs Charged to Patients	0.607627	560,428	340,531	73
76	CARDIAC REHAB	0.871975			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.323684	113,031	149,617	90
90.01	PAIN MANAGEMENT CLINIC	1.445293			90.01
91	Emergency	0.431160	113	49	91
92	Observation Beds (Non-Distinct Part)	1.045678			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,551,376	1,363,566	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,551,376		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	0.305409			50
52	Delivery Room & Labor Room	0.359366			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.161369	15,095	2,436	54
54.01	RADIOLOGY-ULTRASOUND	0.133761	2,406	322	54.01
60	Laboratory	0.170249	44,345	7,550	60
62	Whole Blood & Packed Red Blood Cells	0.307767	2,386	734	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.630645	43,625	27,512	65
66	Physical Therapy	0.561995	133,990	75,302	66
69	Electrocardiology	0.114654	233	27	69
71	Medical Supplies Charged to Patients	0.547761	65,803	36,044	71
72	Impl. Dev. Charged to Patients	0.299469			72
73	Drugs Charged to Patients	0.607627	99,624	60,534	73
76	CARDIAC REHAB	0.871975			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.323684			90
90.01	PAIN MANAGEMENT CLINIC	1.445293			90.01
91	Emergency	0.431160			91
92	Observation Beds (Non-Distinct Part)	1.045678			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		407,507	210,461	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		407,507		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

Check	**[ ] Title V**	**[ ] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[XX] PPS**
Applicable	**[XX] Title XVIII, Part A**	**[ ] IPF**	**[XX] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
Boxes:	**[ ] 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				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.305409			50
52	Delivery Room & Labor Room	0.359366			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.161369	10,235	1,652	54
54.01	RADIOLOGY-ULTRASOUND	0.133761	1,326	177	54.01
60	Laboratory	0.170249	70,022	11,921	60
62	Whole Blood & Packed Red Blood Cells	0.307767	14,048	4,324	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.630645	23,944	15,100	65
66	Physical Therapy	0.561995	681,410	382,949	66
69	Electrocardiology	0.114654	5,717	655	69
71	Medical Supplies Charged to Patients	0.547761	7,968	4,365	71
72	Impl. Dev. Charged to Patients	0.299469			72
73	Drugs Charged to Patients	0.607627	48,295	29,345	73
76	CARDIAC REHAB	0.871975			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.323684			90
90.01	PAIN MANAGEMENT CLINIC	1.445293			90.01
91	Emergency	0.431160	7,226	3,116	91
92	Observation Beds (Non-Distinct Part)	1.045678			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		870,191	453,604	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		870,191		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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)	7,610,284			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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)	7,610,284			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 (see instructions)	7,686,387			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, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	77,504			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,211,463			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)	4,397,420			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)	4,397,420			30
31	Primary payer payments	1,481			31
32	Subtotal (line 30 minus line 31)	4,395,939			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)	446,896			34
35	Adjusted reimbursable bad debts (see instructions)	290,482			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	292,713			36
37	Subtotal (see instructions)	4,686,421			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)	4,686,421			40
40.01	Sequestration adjustment (see instructions)	93,728			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	4,682,585			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-89,892			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

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	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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 (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, 4.01, 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
40.02	Demonstration payment adjustment amount after sequestration				40.02
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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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				2,262,310		4,495,067	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	11/22/2017	195,930	11/22/2017	187,518	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		195,930		187,518	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)				2,458,240		4,682,585	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		2,815			6.01
	based on the cost report (1)		.02				-89,892	6.02
7	Total Medicare program liability (see instructions)				2,461,055		4,592,693	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes: **[ ] Hospital [ ] SUB (Other) [ ] IPF [ ] SNF [ ] IRF [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				625,051			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	11/22/2017	17,793			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		17,793			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)				642,844			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		20,665			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				663,509			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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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				585,018			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)				585,018			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		1,244			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				586,262			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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	466,886		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)	212,566		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	359		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)	679,452		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	679,452		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	679,452		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,113		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)	675,339		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)	2,632		17
17.01	Adjusted reimbursable bad debts (see instructions)	1,711		17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,632		18
19	Total (see instructions)	677,050		19
19.01	Sequestration adjustment (see instructions)	13,541		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	642,844		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	20,665		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	2,774,819	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,774,819	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,802,567	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)	2,802,567	19
20	Deductibles (exclude professional component)	329,684	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,472,883	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	2,472,883	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	59,074	25
26	Adjusted reimbursable bad debts (see instructions)	38,398	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,548	27
28	Subtotal (sum of lines 24 and 26)	2,511,281	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,511,281	30
30.01	Sequestration adjustment (see instructions)	50,226	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	2,458,240	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	2,815	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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

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

	PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	734,323	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	734,323	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	137,366	7
8	Allowable bad debts (see instructions)	1,954	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)	1,270	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)	598,227	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)	598,227	15
15.01	Sequestration adjustment (see instructions)	11,965	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	585,018	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)	1,244	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

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	5,431,408				1
2	Temporary investments	1,203,396				2
3	Notes receivable					3
4	Accounts receivable	7,904,703				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-3,100,000				6
7	Inventory	1,233,768				7
8	Prepaid expenses	758,386				8
9	Other current assets	266,273				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	13,697,934				11
	FIXED ASSETS					
12	Land	490,645				12
13	Land improvements	1,115,487				13
14	Accumulated depreciation	-688,382				14
15	Buildings	54,744,176				15
16	Accumulated depreciation	-21,784,557				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	13,960,574				23
24	Accumulated depreciation	-11,038,231				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	36,799,712				30
	OTHER ASSETS					
31	Investments	17,060,381				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,034,707				34
35	Total other assets (sum of lines 31-34)	21,095,088				35
36	Total assets (sum of lines 11, 30 and 35)	71,592,734				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	1,350,456				37
38	Salaries, wages and fees payable	2,750,074				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	1,164,743				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,796,806				44
45	Total current liabilities (sum of lines 37 thru 44)	7,062,079				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	11,010,000				47
48	Unsecured loans					48
49	Other long term liabilities	4,034,707				49
50	Total long term liabilities (sum of lines 46 thru 49)	15,044,707				50
51	Total liabilities (sum of lines 45 and 50)	22,106,786				51
	CAPITAL ACCOUNTS					
52	General fund balance	49,485,948				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)	49,485,948				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	71,592,734				60

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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		48,171,384			1
2	Net income (loss) (from Worksheet G-3, line 29)		1,314,564			2
3	Total (sum of line 1 and line 2)		49,485,948			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)		49,485,948			11
12	Deductions (debit adjustments) (specify)					12
13	TRANSFER PERM RESTRICTED					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)		49,485,948			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	TRANSFER PERM RESTRICTED					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

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	2,548,113		2,548,113	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	120,982		120,982	5
6	Swing Bed - NF				6
7	Skilled nursing facility	1,225,306		1,225,306	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	3,894,401		3,894,401	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)	3,894,401		3,894,401	17
18	Ancillary services	10,690,878	55,491,214	66,182,092	18
19	Outpatient services		15,338,707	15,338,707	19
20	Rural Health Clinic (RHC)		6,434,348	6,434,348	20
20.01	RHC II		486,791	486,791	20.01
20.02	RHC III		886,369	886,369	20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		749,612	749,612	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN PRIVATE OFFICE		1,266,872	1,266,872	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	14,585,279	80,653,913	95,239,192	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		45,833,787	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	RECONCILING ITEM	-242,653		37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)		-242,653	42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		45,591,134	43

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	95,239,192	1
2	Less contractual allowances and discounts on patients' accounts	50,387,017	2
3	Net patient revenues (line 1 minus line 2)	44,852,175	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	45,591,134	4
5	Net income from service to patients (line 3 minus line 4)	-738,959	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	156,222	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	201,084	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	29,323	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	234,861	22
23	Governmental appropriations	49,333	23
24	Other (CONSULTING CLINIC)	89,524	24
24.01	Other (WELLNESS)	53,081	24.01
24.02	Other (GRANTS)		24.02
24.03	Other (MEANING FULL USE)	149,050	24.03
24.04	Other (FOUNDATION REIMBURSEMENT)		24.04
24.05	Other (DONATIONS)	17,168	24.05
24.06	Other (OTHER INCOME)	543,075	24.06
24.07	Other (TAX SUPPORT)	530,802	24.07
25	Total other income (sum of lines 6-24)	2,053,523	25
26	Total (line 5 plus line 25)	1,314,564	26
29	Net income (or loss) for the period (line 26 minus line 28)	1,314,564	29

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	115,515	7,508	239	20,811	21,644	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	263,307	17,115	14,084			6
7	Physical Therapy	43,987	2,859	5,557			7
8	Occupational Therapy	9,190	582	893			8
9	Speech Pathology	533		290			9
10	Medical Social Services						10
11	Home Health Aide	36,667	2,383	5,389			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)	469,199	30,447	26,452	20,811	21,644	24

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	165,717	13,058	178,775	-10,451	168,324	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	294,506		294,506		294,506	6
7	Physical Therapy	52,403		52,403		52,403	7
8	Occupational Therapy	10,665		10,665		10,665	8
9	Speech Pathology	823		823		823	9
10	Medical Social Services						10
11	Home Health Aide	44,439		44,439		44,439	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)	568,553	13,058	581,611	-10,451	571,160	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	168,324				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	294,506				6
7	Physical Therapy	52,403				7
8	Occupational Therapy	10,665				8
9	Speech Pathology	823				9
10	Medical Social Services					10
11	Home Health Aide	44,439				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)	571,160				24

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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		168,324	168,324		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		294,506	123,059	417,565	6
7	Physical Therapy		52,403	21,896	74,299	7
8	Occupational Therapy		10,665	4,456	15,121	8
9	Speech Pathology		823	344	1,167	9
10	Medical Social Services					10
11	Home Health Aide		44,439	18,569	63,008	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)		571,160		571,160	24

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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					-168,324	402,836	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						294,506	6
7	Physical Therapy						52,403	7
8	Occupational Therapy						10,665	8
9	Speech Pathology						823	9
10	Medical Social Services							10
11	Home Health Aide						44,439	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)					-168,324	402,836	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						168,324	25
26	Unit Cost Multiplier						0.417847	26

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			1,649	22,320	1,210		1
2	Skilled Nursing Care	417,565			50,876			2
3	Physical Therapy	74,299			8,499			3
4	Occupational Therapy	15,121			1,776			4
5	Speech Pathology	1,167			103			5
6	Medical Social Services							6
7	Home Health Aide	63,008			7,085			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)	571,160		1,649	90,659	1,210		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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	MAIN-TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	Administrative and General	814		16,979	42,972	5,167		1
2	Skilled Nursing Care				468,441	56,323		2
3	Physical Therapy				82,798	9,955		3
4	Occupational Therapy				16,897	2,032		4
5	Speech Pathology				1,270	153		5
6	Medical Social Services							6
7	Home Health Aide				70,093	8,428		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)	814		16,979	682,471	82,058		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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General			2,584		17,507		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)			2,584		17,507		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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		13	14	15	16	17	19	
1	Administrative and General	65,135				898		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)	65,135				898		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.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	
		20	21	22	23	24	25	
1	Administrative and General					134,263		1
2	Skilled Nursing Care					524,764		2
3	Physical Therapy					92,753		3
4	Occupational Therapy					18,929		4
5	Speech Pathology					1,423		5
6	Medical Social Services							6
7	Home Health Aide					78,521		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)					850,653		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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7175** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	TOTAL HHA COSTS				
		26	27	28				
1	Administrative and General	134,263						1
2	Skilled Nursing Care	524,764	98,349	623,113				2
3	Physical Therapy	92,753	17,383	110,136				3
4	Occupational Therapy	18,929	3,548	22,477				4
5	Speech Pathology	1,423	267	1,690				5
6	Medical Social Services							6
7	Home Health Aide	78,521	14,716	93,237				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)	850,653	134,263	850,653				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.		0.187416					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.

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		1,833	115,515	9		11,250	1
2	Skilled Nursing Care			263,307				2
3	Physical Therapy			43,987				3
4	Occupational Therapy			9,190				4
5	Speech Pathology			533				5
6	Medical Social Services							6
7	Home Health Aide			36,667				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)		1,833	469,199	9		11,250	20
21	Total cost to be allocated		1,649	90,659	1,210		814	21
22	Unit Cost Multiplier			0.193221				22
22	Unit Cost Multiplier		0.899618		134.444444		0.072356	22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	4A.06	5.06	6	7	
1	Administrative and General		749,612		42,972			1
2	Skilled Nursing Care				468,441			2
3	Physical Therapy				82,798			3
4	Occupational Therapy				16,897			4
5	Speech Pathology				1,270			5
6	Medical Social Services							6
7	Home Health Aide				70,093			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)		749,612		682,471			20
21	Total cost to be allocated		16,979		82,058			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		0.022650		0.120237			22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-2 PART II**

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION NURSING HOURS	
		8	9	10	11	12	13	
1	Administrative and General		450		8		17,268	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		450		8		17,268	20
21	Total cost to be allocated		2,584		17,507		65,135	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		5.742222		2,188.375000		3.772006	22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	
		14	15	16	17	19	20	
1	Administrative and General				1			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)				1			20
21	Total cost to be allocated				898			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				898.000000			22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7175** **WORKSHEET H-2 PART II**

	HHA COST CENTER	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME				
		21	22	23				
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	623,113		623,113	2,051	303.81	1
2	Physical Therapy	3	110,136		110,136	838	131.43	2
3	Occupational Therapy	4	22,477		22,477	164	137.05	3
4	Speech Pathology	5	1,690		1,690	48	35.21	4
5	Medical Social Services	6						5
6	Home Health Aide	7	93,237		93,237	350	266.39	6
7	Total (sum of lines 1-6)		850,653		850,653	3,451		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		1,600		8
9	Physical Therapy	99914		682		9
10	Occupational Therapy	99914		145		10
11	Speech Pathology	99914		28		11
12	Medical Social Services	99914				12
13	Home Health Aide	99914		340		13
14	Total (sum of lines 8-13)			2,795		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		16,253	16,253	29,672	0.547755	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	0.561995			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	0.547761	29,672	16,253	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.607627			col. 2, line 16	5

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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		1,600			486,096		486,096	1
2	Physical Therapy		682			89,635		89,635	2
3	Occupational Therapy		145			19,872		19,872	3
4	Speech Pathology		28			986		986	4
5	Medical Social Services								5
6	Home Health Aide		340			90,573		90,573	6
7	Total (sum of lines 1-6)		2,795			687,162		687,162	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

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		408,249	11
12	Total PPS Reimbursement - Full Episodes with Outliers		1,709	12
13	Total PPS Reimbursement - LUPA Episodes		5,185	13
14	Total PPS Reimbursement - PEP Episodes		4,320	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		479	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)		419,942	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		419,942	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		419,942	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)		419,942	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		419,942	31
31.01	Sequestration adjustment (see instructions)		8,399	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		411,543	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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						411,543	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)						411,543	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)						411,543	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
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
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
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
192.10	PHYSICIAN HOSPITALIST							192.10
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
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201

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		
202	TOTAL (sum of lines 118-201)							202

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	2,060,894		2,060,894	-23,727	2,037,167	-81,358	1,955,809	1
2	Physician Assistant								2
3	Nurse Practitioner	6,720		6,720		6,720		6,720	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	1,199,794	212,384	1,412,178		1,412,178		1,412,178	9
10	Subtotal (sum of lines 1 through 9)	3,267,408	212,384	3,479,792	-23,727	3,456,065	-81,358	3,374,707	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		131,739	131,739		131,739		131,739	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment				164,846	164,846		164,846	17
18	Professional Liability Insurance								18
19	Other Health Care Costs		160,831	160,831		160,831		160,831	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		292,570	292,570	164,846	457,416		457,416	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,267,408	504,954	3,772,362	141,119	3,913,481	-81,358	3,832,123	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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		102,940	102,940	79,249	182,189		182,189	29
30	Administrative Costs	618,174	199,738	817,912		817,912		817,912	30
31	Total Facility Overhead (sum of lines 29 and 30)	618,174	302,678	920,852	79,249	1,000,101		1,000,101	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	3,885,582	807,632	4,693,214	220,368	4,913,582	-81,358	4,832,224	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.

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	5.02	24,856	4,200	21,084		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.91	4,088	2,100	1,911		3
4	Subtotal (sum of lines 1 through 3)	5.93	28,944		22,995	28,944	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)	5.93	28,944			28,944	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)	3,832,123	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)	3,832,123	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)	1,000,101	14
15	Parent provider overhead allocated to facility (see instructions)	1,560,218	15
16	Total overhead (sum of lines 14 and 15)	2,560,319	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	2,560,319	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	2,560,319	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	6,392,442	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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)	6,392,442	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	261,674	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	6,130,768	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	28,944	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	28,944	6
7	Adjusted cost per visit (line 3 divided by line 6)	211.81	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)	211.81	211.81	211.81	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		7,453		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,578,620		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)		1,578,620		16
16.01	Total program charges (see instructions)(from contractor's records)		1,187,065		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		142,192		16.02
16.03	Total program preventive costs (see instructions)		189,095		16.03
16.04	Total program non-preventive costs (see instructions)		1,003,313		16.04
16.05	Total program cost (see instructions)		1,192,408		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		135,384		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		181,898		19
20	Net Medicare cost excluding vaccines (see instructions)		1,192,408		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		188,010		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,380,418		22
23	Allowable bad debts (see instructions)		45,666		23
23.01	Adjusted reimbursable bad debts (see instructions)		29,683		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		45,666		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,410,101		26
26.01	Sequestration adjustment (see instructions)		28,202		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		1,069,517		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		312,382		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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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)	3,374,707	3,374,707	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000854	0.019730	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,882	66,583	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	70,803	16,599	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	73,685	83,182	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	3,832,123	3,832,123	6
7	Total overhead (from Wkst. M-2, line 16)	2,560,319	2,560,319	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.019228	0.021707	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	49,230	55,577	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	122,915	138,759	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	446	1,031	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	275.59	134.59	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	334	713	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	92,047	95,963	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)		261,674	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)		188,010	16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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				1,133,743	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	11/22/2017	64,226	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		-64,226	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				1,069,517	
	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		312,382	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				1,381,899	
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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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								1
2	Physician Assistant								2
3	Nurse Practitioner	99,542		99,542		99,542		99,542	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	136,385	23,381	159,766		159,766	-9,299	150,467	9
10	Subtotal (sum of lines 1 through 9)	235,927	23,381	259,308		259,308	-9,299	250,009	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		12,781	12,781		12,781		12,781	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment				6,791	6,791		6,791	17
18	Professional Liability Insurance								18
19	Other Health Care Costs		3,724	3,724		3,724		3,724	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		16,505	16,505	6,791	23,296		23,296	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	235,927	39,886	275,813	6,791	282,604	-9,299	273,305	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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		39,099	39,099		39,099		39,099	29
30	Administrative Costs	18,666	14,954	33,620		33,620		33,620	30
31	Total Facility Overhead (sum of lines 29 and 30)	18,666	54,053	72,719		72,719		72,719	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	254,593	93,939	348,532	6,791	355,323	-9,299	346,024	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.

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	3,136	2,100	1,680		3
4	Subtotal (sum of lines 1 through 3)	0.80	3,136		1,680	3,136	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	3,136			3,136	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)	273,305	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)	273,305	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)	72,719	14
15	Parent provider overhead allocated to facility (see instructions)	100,067	15
16	Total overhead (sum of lines 14 and 15)	172,786	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	172,786	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	172,786	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	446,091	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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)	446,091	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	8,502	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	437,589	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	3,136	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	3,136	6
7	Adjusted cost per visit (line 3 divided by line 6)	139.54	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)	139.54	139.54	139.54	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		552		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		77,026		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)		77,026		16
16.01	Total program charges (see instructions)(from contractor's records)		87,098		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,690		16.02
16.03	Total program preventive costs (see instructions)		10,338		16.03
16.04	Total program non-preventive costs (see instructions)		43,709		16.04
16.05	Total program cost (see instructions)		54,047		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		12,052		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,671		19
20	Net Medicare cost excluding vaccines (see instructions)		54,047		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,994		21
22	Total reimbursable Program cost (line 20 plus line 21)		60,041		22
23	Allowable bad debts (see instructions)		5,026		23
23.01	Adjusted reimbursable bad debts (see instructions)		3,267		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,026		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		63,308		26
26.01	Sequestration adjustment (see instructions)		1,266		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		46,637		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		15,405		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.

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)	250,009	250,009	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000295	0.002405	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	74	601	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,699	1,835	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,773	2,436	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	273,305	273,305	6
7	Total overhead (from Wkst. M-2, line 16)	172,786	172,786	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010146	0.008913	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,753	1,540	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	4,526	3,976	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	17	114	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	266.24	34.88	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	14	65	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	3,727	2,267	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)		8,502	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)		5,994	16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				46,637	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)				46,637	
	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		15,405	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				62,042	
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.

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	94,875		94,875	10,481	105,356	-3,650	101,706	1
2	Physician Assistant								2
3	Nurse Practitioner	119,843		119,843		119,843		119,843	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	166,692	20,030	186,722		186,722		186,722	9
10	Subtotal (sum of lines 1 through 9)	381,410	20,030	401,440	10,481	411,921	-3,650	408,271	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		10,948	10,948		10,948		10,948	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment				66,283	66,283		66,283	17
18	Professional Liability Insurance								18
19	Other Health Care Costs		3,191	3,191		3,191		3,191	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		14,139	14,139	66,283	80,422		80,422	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	381,410	34,169	415,579	76,764	492,343	-3,650	488,693	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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		33,495	33,495		33,495		33,495	29
30	Administrative Costs	19,978	12,809	32,787		32,787		32,787	30
31	Total Facility Overhead (sum of lines 29 and 30)	19,978	46,304	66,282		66,282		66,282	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	401,388	80,473	481,861	76,764	558,625	-3,650	554,975	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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	0.17	1,438	4,200	714		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.82	3,929	2,100	1,722		3
4	Subtotal (sum of lines 1 through 3)	0.99	5,367		2,436	5,367	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)	0.99	5,367			5,367	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)	488,693	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)	488,693	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)	66,282	14
15	Parent provider overhead allocated to facility (see instructions)	167,121	15
16	Total overhead (sum of lines 14 and 15)	233,403	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	233,403	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	233,403	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	722,096	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: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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)	722,096	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	15,422	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	706,674	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	5,367	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	5,367	6
7	Adjusted cost per visit (line 3 divided by line 6)	131.67	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)	131.67	131.67	131.67	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		722		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		95,066		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)		95,066		16
16.01	Total program charges (see instructions)(from contractor's records)		111,299		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		7,931		16.02
16.03	Total program preventive costs (see instructions)		6,774		16.03
16.04	Total program non-preventive costs (see instructions)		61,119		16.04
16.05	Total program cost (see instructions)		67,893		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		11,893		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		18,295		19
20	Net Medicare cost excluding vaccines (see instructions)		67,893		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		10,306		21
22	Total reimbursable Program cost (line 20 plus line 21)		78,199		22
23	Allowable bad debts (see instructions)		5,624		23
23.01	Adjusted reimbursable bad debts (see instructions)		3,656		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		3,774		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		81,855		26
26.01	Sequestration adjustment (see instructions)		1,637		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		74,957		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		5,261		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.

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)	408,271	408,271	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000890	0.001564	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	363	639	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	7,938	1,497	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	8,301	2,136	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	488,693	488,693	6
7	Total overhead (from Wkst. M-2, line 16)	233,403	233,403	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.016986	0.004371	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,965	1,020	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	12,266	3,156	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	50	93	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	245.32	33.94	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	38	29	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	9,322	984	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)		15,422	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)		10,306	16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form **CMS-2552-10**	Period : From: 05/01/2017 To: 04/30/2018	Run Date: 09/27/2018 Run Time: 07:56 Version: 2018.04 (09/26/2018)

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				74,957	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)				74,957	
	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		5,261	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				80,218	
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.