

CRAWFORD MEMORIAL HOSPITAL

ROBINSON, ILLINOIS

MEDICARE COST ANALYSIS

YEAR ENDED APRIL 30, 2015



CPAs and
Management Consultants

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Board of Directors
Crawford Memorial Hospital

We have compiled the Hospital Health Care Complex Cost Report Form HCFA 2552-10 of Crawford Memorial Hospital for the year ended April 30, 2015, included in the accompanying prescribed form in accordance with Statements on Standard for Accounting and Review Services issued by the American Institute of Certified Public Accountants.

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

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

Kerber, Eck + Braeckel LLP

Carbondale, Illinois
September 16, 2015

Other Locations

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

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

Dear Sir or Madam:

This cost report of Crawford Memorial Hospital for the fiscal year ended April 30, 2015, includes two Level 20000 Errors.

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

The 20300 error, which reads the cost to charge ratio on Wkst C, Part I, Col. 11 should not be more than 100% or less than .1%, Line 90 is a result of a majority of revenue generated in this cost center resulting from surgeries being performed by Clinic physicians at the Hospital for Short Stay Surgery. Since the surgery is performed at the hospital, technical component charges are properly billed and posted to the operating room cost center where the cost is incurred. The physician charges and other clinic charges are posted to the Clinic cost center. Therefore, the Clinic cost center does not generate enough charges to cover the expense of running the clinic which includes the cost report allocated overhead expenses.

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 09/16/2015 Time: 08:16
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CRAWFORD MEMORIAL HOSPITAL (14-1343) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 05/01/2014 and ending 04/30/2015, 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.

ECR Encryption: 09/16/2015 08:16
HM96SvusscIRywJO9jmWVtZkFg4Fp0
QAE5Y0kzOT7Ac0AbQBCLqVJIYN76C
v7RY1y3UKq0uH59i

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

Title

Date

PI Encryption: 09/16/2015 08:16
u3Pfi84HoImWW9w1wqn.z0r0y0oNb0
FWi1C0.0B68Yp6kNCKzVzJpHI59sSq
cGrC0KUHI096kuV

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT 4	TITLE XIX 5	
		TITLE V 1	PART A 2			
1	HOSPITAL		304,220	-327,645		1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF		54,203			5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY		-3,277	383		9
10	HEALTH CLINIC - RHC			228,472		10
10.01	HEALTH CLINIC - RHC II			4,604		10.01
10.02	HEALTH CLINIC - RHC III			272		10.02
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL		355,146	-93,914		200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

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 / 2014	To: 04 / 30 / 2015	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 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 in effect in the cost reporting period.							37

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
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
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
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
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

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 as defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1. (see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63
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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 column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				64

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

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all 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 Facility PPS		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

Rural Providers

		1	2		
		Y			
105	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105	
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106	
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be 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	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	N	109	
		Physical	Occupational	Speech	Respiratory
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, 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

Transplant Center Information

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

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

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

		Title XVIII		Title V	Title XIX	
		Part A	Part B			
		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	
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)				169	
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			05 / 01 / 2014	04 / 30 / 2015	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)				N	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts		Y	
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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/30/2015	Y	06/30/2015	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 Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

Capital Related 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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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	81,840.00		1,953	466	3,410	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						244		244	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	81,840.00		2,197	466	3,654	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	81,840.00		2,197	673	3,957	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	48	17,520			1,479		7,912	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					4,040		4,690	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					7,550		27,211	26
26.01	RHC II	88.01					520		4,508	26.01
26.02	RHC III	88.02					480		5,283	26.02
27	Total (sum of lines 14-26)		73							27
28	Observation Bed Days							120	476	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							38	60	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					469	213	947	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)		262.45			469	213	947	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		19.80						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		8.82						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		45.93						26
26.01	RHC II		4.58						26.01
26.02	RHC III		4.53						26.02
27	Total (sum of lines 14-26)		346.11						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 14-7175

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

County: [CLICK HERE TO ENTER](#)

	Description	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total 5	
1	Home Health Aide Hours		795		5	800	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 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)		1.03	1.03	4
5	Other Administrative Personnel		1.00	1.00	5
6	Direct Nursing Service		4.24	4.24	6
7	Nursing Supervisor				7
8	Physical Therapy Service		0.32	0.32	8
9	Physical Therapy Supervisor		0.26	0.26	9
10	Occupational Therapy Service		0.14	0.14	10
11	Occupational Therapy Supervisor				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		1.78	1.78	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				Total (columns 1 through 4)	
		Without Outliers 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4		
21	Skilled Nursing Visits	1,727	487	45	56	2,315	21
22	Skilled Nursing Visit Charges	333,039	95,288	8,155	10,589	447,071	22
23	Physical Therapy Visits	626	8	5	19	658	23
24	Physical Therapy Visit Charges	125,486	1,608	995	3,659	131,748	24
25	Occupational Therapy Visits	211	2		7	220	25
26	Occupational Therapy Visit Charges	42,161	402		1,357	43,920	26
27	Speech Pathology Visits	40			10	50	27
28	Speech Pathology Visit Charges	8,020			1,940	9,960	28
29	Medical Social Service Visits	2				2	29
30	Medical Social Service Visit Charges	554				554	30
31	Home Health Aide Visits	630	127	16	22	795	31
32	Home Health Aide Visit Charges	42,978	10,757	92	1,320	55,147	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,236	624	66	114	4,040	33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	552,238	108,055	9,242	18,865	688,400	35
36	Total Number of Episodes (standard/non-outlier)	183		18	7	208	36
37	Total Number of Ourlier Episodes		13			13	37
38	Total Non-Routine Medical Supply Charges	33,295	12,066	1,286	1,039	47,686	38

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes 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				14
15	RVC	16		16	15
16	RVB				16
17	RVA				17
18	RHC	22		22	18
19	RHB	41		41	19
20	RHA	32		32	20
21	RMC	337		337	21
22	RMB	45		45	22
23	RMA	494		494	23
24	RLB				24
25	RLA	8		8	25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2	45		45	31
32	HD1	14		14	32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1	16		16	36
37	LE2	14		14	37
38	LE1	5		5	38
39	LD2				39
40	LD1	32		32	40
41	LC2	12		12	41
42	LC1				42
43	LB2	12		12	43
44	LB1	11		11	44
45	CE2				45
46	CE1	18		18	46
47	CD2				47
48	CD1	36		36	48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1	10		10	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	15		15	65
66	BB1	4		4	66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1	15		15	70
71	PD2				71

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PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1	75		75	72
73	PC2	21		21	73
74	PC1				74
75	PB2				75
76	PB1	103		103	76
77	PA2				77
78	PA1	21		21	78
199	AAA				199
200	TOTAL	1,479		1,479	200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
	1	2	3	4
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).	00014	00014	201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing	710,215	53.28%		202
203	Recruitment				203
204	Retention of employees				204
205	Training	3,432	0.26%		205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	1,333,042			207

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT CCN: 14-3429

WORKSHEET S-8

Check applicable box: RHC FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday	
		from	to	from	to	from	to	from	to	from	to	from	to	from	to
11	Clinic	0800	1700	0800	1700	0800	1700	0800	1700	0800	1700	0800	1700	13	14

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

12	Have you received an approval for an exception to the productivity standard?	1 N	2 12
13	Is this a consolidated cost report as defined in CMS Pub. 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.	1 N	2 13
14	Provider name: _____ CCN number: _____		14

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT CCN: 14-3486

WORKSHEET S-8

Check applicable box: RHC FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to	from	to	
11	Clinic	0800	1630	0800	1630	0800	1630	0800	1630	0800	1630	0800	1630	13	14	11

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

12	Have you received an approval for an exception to the productivity standard?	1 N	2	12
13	Is this a consolidated cost report as defined in CMS Pub. 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.	1 N	2	13
14	Provider name: _____ CCN number: _____			14

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER
STATISTICAL DATA

COMPONENT CCN: 14-3488

WORKSHEET S-8

Check applicable box: RHC FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

	Type Operation	Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to			
11	Clinic	0800	1700	0800	1700	0800	1700	0800	1700	0800	1700	0800	1700	13	14	11

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

12	Have you received an approval for an exception to the productivity standard?	1 N	2 12
13	Is this a consolidated cost report as defined in CMS Pub. 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.	1 N	2 13
14	Provider name: _____ CCN number: _____		14

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

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.437653	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,153,958	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	3,027,335	5
6	Medicaid charges	17,915,046	6
7	Medicaid cost (line 1 times line 6)	7,840,574	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.	1,659,281	8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fund 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)			1,659,281	19
		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,293,161	809,636	2,102,797	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	565,956	354,340	920,296	21
22	Partial payment by patients approved for charity care	206,915	129,532	336,447	22
23	Cost of charity care (line 21 minus line 22)	359,041	224,808	583,849	23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)				25
26	Total bad debt expense for the entire hospital complex (see instructions)			1,845,102	26
27	Medicare bad debts for the entire hospital complex (see instructions)			447,674	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			1,397,428	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			611,589	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			1,195,438	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,854,719	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		2,258,768	2,258,768	253,887	2,512,655	-72,792	2,439,863	1
2	00200	Cap Rel Costs-Mvble Equip		849,284	849,284	4,731	854,015	-195,118	658,897	2
3	00300	Other Cap Rel Costs		24,319	24,319	-24,319			-0-	3
4	00400	Employee Benefits Department	203,679	4,149,487	4,353,166	5,878	4,359,044	-211,081	4,147,963	4
5.01	00540	NONPATIENT TELEPHONES		2	2	32,503	32,505		32,505	5.01
5.02	00550	DATA PROCESSING	197,460	775,158	972,618		972,618		972,618	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	159,360	42,644	202,004		202,004		202,004	5.03
5.04	00570	ADMITTING	348,978	73,539	422,517	-33,248	389,269		389,269	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	283,864	379,857	663,721		663,721		663,721	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	561,220	2,352,920	2,914,140		2,914,140	-363,584	2,550,556	5.06
7	00700	Operation of Plant	415,202	1,163,967	1,579,169	31,709	1,610,878	-1,252	1,609,626	7
8	00800	Laundry & Linen Service	96,938	48,456	145,394		145,394		145,394	8
9	00900	Housekeeping	343,671	152,610	496,281		496,281		496,281	9
10	01000	Dietary	474,712	434,938	909,650	-464,007	445,643		445,643	10
11	01100	Cafeteria				464,007	464,007	-203,715	260,292	11
13	01300	Nursing Administration	696,426	76,262	772,688		772,688		772,688	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	566,142	236,793	802,935		802,935	-2,266	800,669	15
16	01600	Medical Records & Library	640,238	178,528	818,766	2,621	821,387	-9,146	812,241	16
17	01700	Social Service	39,646	2,952	42,598		42,598		42,598	17
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,998,851	368,299	2,367,150	-157,212	2,209,938	-109,656	2,100,282	30
43	04300	Nurserv		7	7	54,119	54,126		54,126	43
44	04400	Skilled Nursing Facility	710,215	200,083	910,298	165,229	1,075,527		1,075,527	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	908,522	496,216	1,404,738	878,163	2,282,901	-756,799	1,526,102	50
52	05200	Delivery Room & Labor Room				103,093	103,093		103,093	52
53	05300	Anesthesiology	626,382	251,781	878,163	-878,163				53
54	05400	Radiology-Diagnostic	671,939	713,773	1,385,712	-17,679	1,368,033	-900	1,367,133	54
54.01	05401	RADIOLOGY-ULTRASOUND		208,500	208,500		208,500		208,500	54.01
60	06000	Laboratory	577,461	1,136,080	1,713,541	-149,504	1,564,037		1,564,037	60
62	06200	Whole Blood & Packed Red Blood Cells				149,504	149,504		149,504	62
65	06500	Respiratory Therapy	373,427	190,253	563,680		563,680	-20,000	543,680	65
66	06600	Physical Therapy	759,943	348,012	1,107,955	-3,800	1,104,155		1,104,155	66
69	06900	Electrocardiology	23,463	3,229	26,692		26,692		26,692	69
71	07100	Medical Supplies Charged to Patients		718,945	718,945	16,629	735,574		735,574	71
72	07200	Impl. Dev. Charged to Patients		108,529	108,529		108,529		108,529	72
73	07300	Drugs Charged to Patients		1,668,160	1,668,160	17,679	1,685,839		1,685,839	73
76	03950	CARDIAC REHAB	36,339	1,801	38,140		38,140		38,140	76
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	3,874,922	459,641	4,334,563	204,025	4,538,588	-397,934	4,140,654	88
88.01	08801	RHC II	268,728	164,008	432,736	7,636	440,372	-15,808	424,564	88.01
88.02	08802	RHC III	400,509	159,645	560,154	28,930	589,084	-9,111	579,973	88.02
90	09000	Clinic	2,204,376	1,607,817	3,812,193	4,237	3,816,430	-2,400,013	1,416,417	90
91	09100	Emergency	737,769	1,420,825	2,158,594		2,158,594	-995,800	1,162,794	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	483,695	138,199	621,894	-13,874	608,020	-34,501	573,519	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		634,821	634,821	-634,821				113
118		SUBTOTALS (sum of lines 1-117)	19,684,077	24,199,108	43,883,185	47,953	43,931,138	-5,799,476	38,131,662	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	112,183	160,426	272,609	19,859	292,468		292,468	192
194	07950	NONREIMBURSEABLE								194
194.01	07951	PROFESSIONAL BUILDINGS		147,913	147,913	-63,698	84,215		84,215	194.01
194.02	07952	FOUNDATION SERVICES	26,957	11,801	38,758		38,758		38,758	194.02
194.03	07953	WELLNESS	94,784	18,708	113,492	-4,114	109,378		109,378	194.03
194.04	07954	RENTED SPACE								194.04
200		TOTAL (sum of lines 118-199)	19,918,001	24,537,956	44,455,957		44,455,957	-5,799,476	38,656,481	200

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
1		1	2	3	4	5	
1	R/C HHA MED SUPPLIES	A	Medical Supplies Charged to P	71		16,629	1
500	Total reclassifications					16,629	500
	Code Letter - A						
1	LTC ADMITTING COSTS	D	Skilled Nursing Facility	44	615	130	1
500	Total reclassifications				615	130	500
	Code Letter - D						
1	R/C CAFETERIA COSTS	F	Cafeteria	11	242,148	221,859	1
500	Total reclassifications				242,148	221,859	500
	Code Letter - F						
1	R/C COST OF BLOOD	G	Whole Blood & Packed Red Bloo	62		149,504	1
500	Total reclassifications					149,504	500
	Code Letter - G						
1	PBX COST	H	NONPATIENT TELEPHONES	5.01	26,842	5,661	1
500	Total reclassifications				26,842	5,661	500
	Code Letter - H						
1	R/C DEPR OBLONG CLINIC	I					1
500	Total reclassifications						500
	Code Letter - I						
1	R/C DEPR PROF BLDGS	J	PROFESSIONAL BUILDINGS	194.01		20,164	1
2			Rural Health Clinic	88		182,969	2
3			RHC II	88.01		7,636	3
4			Clinic	90		20,750	4
5			Home Health Agency	101		2,755	5
6			WELLNESS	194.03		1,764	6
500	Total reclassifications					236,038	500
	Code Letter - J						
1	R/C SNF DEPR	K	Skilled Nursing Facility	44		164,484	1
500	Total reclassifications					164,484	500
	Code Letter - K						
1	R/C LABOR/DEL & NB COSTS	L	Nursery	43	45,283	8,836	1
2			Delivery Room & Labor Room	52	86,250	16,843	2
500	Total reclassifications				131,533	25,679	500
	Code Letter - L						
1	R/C TRANSCRIPTION TXFR	N	Medical Records & Library	16		2,621	1
2							2
500	Total reclassifications					2,621	500
	Code Letter - N						
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	O	Drugs Charged to Patients	73		17,679	1
500	Total reclassifications					17,679	500
	Code Letter - O						
1	R/C OR COST	Q	Operating Room	50	626,382	251,781	1
500	Total reclassifications				626,382	251,781	500
	Code Letter - Q						
1	R/C PALESTINE/OBLONG DRS	R					1
2			Physicians' Private Offices	192		19,859	2
3			RHC III	88.02		27,901	3
500	Total reclassifications					47,760	500
	Code Letter - R						
1	HEALTHWORKS COST	U	Employee Benefits Department	4	4,909	969	1
500	Total reclassifications				4,909	969	500
	Code Letter - U						
1	UTILITIES	V	Operation of Plant	7		31,709	1
2							2
3							3
500	Total reclassifications					31,709	500
	Code Letter - V						
1	INTEREST EXPENSE	W	Cap Rel Costs-Bldg & Fixt	1		634,821	1
500	Total reclassifications					634,821	500
	Code Letter - W						
1	RHC UTILITIES & MAINTENANCE	X	Rural Health Clinic	88		61,696	1

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY		OTHER
		1	2	3	4	5	
500	Total reclassifications					61,696	500
	Code Letter - X						
1	RECLASS PROPERTY TAXES	Z	Physical Therapy	66		21,137	1
2			RHC III	88.02		1,029	2
500	Total reclassifications					22,166	500
	Code Letter - Z						
	GRAND TOTAL (Increases)					1,032,429	1,891,186

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES							
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.		
		1	6	7	8	9	10		
1	R/C HHA MED SUPPLIES	A	Home Health Agency	101		16,629		1	
500	Total reclassifications					16,629		500	
	Code letter - A								
1	LTC ADMITTING COSTS	D	ADMITTING	5.04	615	130		1	
500	Total reclassifications				615	130		500	
	Code letter - D								
1	R/C CAFETERIA COSTS	F	Dietary	10	242,148	221,859		1	
500	Total reclassifications				242,148	221,859		500	
	Code letter - F								
1	R/C COST OF BLOOD	G	Laboratory	60		149,504		1	
500	Total reclassifications					149,504		500	
	Code letter - G								
1	PBX COST	H	ADMITTING	5.04	26,842	5,661		1	
500	Total reclassifications				26,842	5,661		500	
	Code letter - H								
1	R/C DEPR OBLONG CLINIC	I					9	1	
500	Total reclassifications							500	
	Code letter - I								
1	R/C DEPR PROF BLDGS	J	Cap Rel Costs-Bldg & Fixt	1		236,038	9	1	
2							9	2	
3							9	3	
4							9	4	
5							9	5	
6							9	6	
500	Total reclassifications					236,038		500	
	Code letter - J								
1	R/C SNF DEPR	K	Cap Rel Costs-Bldg & Fixt	1		164,484	9	1	
500	Total reclassifications					164,484		500	
	Code letter - K								
1	R/C LABOR/DEL & NB COSTS	L	Adults & Pediatrics	30	131,533	25,679		1	
2								2	
500	Total reclassifications				131,533	25,679		500	
	Code letter - L								
1	R/C TRANSCRIPTION TXFR	N	Rural Health Clinic	88		256		1	
2			Clinic	90		2,365		2	
500	Total reclassifications					2,621		500	
	Code letter - N								
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	O	Radiology-Diagnostic	54		17,679		1	
500	Total reclassifications					17,679		500	
	Code letter - O								
1	R/C OR COST	Q	Anesthesiology	53	626,382	251,781		1	
500	Total reclassifications				626,382	251,781		500	
	Code letter - Q								
1	R/C PALESTINE/OBLONG DRS	R	Rural Health Clinic	88		40,384		1	
2			Clinic	90		7,376		2	
3								3	
500	Total reclassifications					47,760		500	
	Code letter - R								
1	HEALTHWORKS COST	U	WELLNESS	194.03	4,909	969		1	
500	Total reclassifications				4,909	969		500	
	Code letter - U								
1	UTILITIES	V						1	
2			Physical Therapy	66		24,937		2	
3			Clinic	90		6,772		3	
500	Total reclassifications					31,709		500	
	Code letter - V								
1	INTEREST EXPENSE	W	Interest Expense	113		634,821	11	1	
500	Total reclassifications					634,821		500	
	Code letter - W								

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	RHC UTILITIES & MAINTENANCE	X	PROFESSIONAL BUILDINGS	194.01		61,696	1	
500	Total reclassifications					61,696	500	
	Code letter - X							
1	RECLASS PROPERTY TAXES	Z	PROFESSIONAL BUILDINGS	194.01		22,166	1	
2							2	
500	Total reclassifications					22,166	500	
	Code letter - Z							
	GRAND TOTAL (Decreases)				1,032,429	1,891,186		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	240,645	50,000		50,000		290,645		1
2	Land Improvements	1,310,228					1,310,228		2
3	Buildings and Fixtures	46,500,436	4,559,433		4,559,433	2,738,626	48,321,243		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	11,483,362	650,315		650,315	76,854	12,056,823		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	59,534,671	5,259,748		5,259,748	2,815,480	61,978,939		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	59,534,671	5,259,748		5,259,748	2,815,480	61,978,939		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	2,258,768						2,258,768	1	
2	Cap Rel Costs-Mvble Equip	849,284						849,284	2	
3	Total (sum of lines 1-2)	3,108,052						3,108,052	3	

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see 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	49,922,117		49,922,117	0.805469			19,588	19,588	1
2	Cap Rel Costs-Mvble Equip	12,056,822		12,056,822	0.194531			4,731	4,731	2
3	Total (sum of lines 1-2)	61,978,939		61,978,939	1.000000			24,319	24,319	3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	1,858,246	-72,792	634,821			19,588	2,439,863	1	
2	Cap Rel Costs-Mvble Equip	654,166					4,731	658,897	2	
3	Total (sum of lines 1-2)	2,512,412	-72,792	634,821			24,319	3,098,760	3	

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)	A	-72,792	Cap Rel Costs-Bldg & Fixt	1	10
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2	2
3	Investment income-other (chapter 2)					3
4	Trace, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)					5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)					7
8	Television and radio service (chapter 21)					8
9	Parking lot (chapter 21)					9
10	Provider-based physician adjustment	Wkst A-8-2	-1,329,513			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	-203,715	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	-9,146	Medical Records & Library	16	18
19	Nursing school (tuition, fees, books, etc.)					19
20	Vending machines					20
21	Income from imposition of interest, finance or penalty charges (chapter 21)					21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	27
28	Non-physician anesthetist			Nonphysician Anesthetists	19	28
29	Physicians' assistant					29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	31
32	CAH HIT Adj for Depreciation	A	-195,118	Cap Rel Costs-Mvble Equip	2	9
33	PHYS RECRUITING	A	-143,811	OTHER ADMINISTRATIVE AND GENERAL	5.06	33
33.11	EMPLOYEE INJURY	A	-7,068	Employee Benefits Department	4	33.11
33.22	EMPLOYEE PHYSICALS	A	-42	Employee Benefits Department	4	33.22
34	ADVERTISING	A	-104,429	OTHER ADMINISTRATIVE AND GENERAL	5.06	34
35	TV ADMINISTRATION	A	-6,738	OTHER ADMINISTRATIVE AND GENERAL	5.06	35
36	TV UTILITIES & REPAIR	A	-1,252	Operation of Plant	7	36
37						37
38	EMPLOYEE DISCOUNTS	A	-46,386	Employee Benefits Department	4	38
39	OTHER A & G	A	-56,567	OTHER ADMINISTRATIVE AND GENERAL	5.06	39
40	EMPLOYEE SALES - PHARMACY	B	-2,266	Pharmacy	15	40
41						41
42	CONSULTING CLINIC	B	-86,340	Clinic	90	42
42.11	OTHER INCOME ROBINSON RHC	B	-208,909	Rural Health Clinic	88	42.11
42.22	OTHER INCOME PALESTINE RHC	B	-15,197	RHC II	88.01	42.22
43						43
44	PHYSICIAN EXPENSES	A	-1,349,477	Clinic	90	44
45	PHYSICIAN EXPENSES	A	-113,858	Employee Benefits Department	4	45
46	PHYSICIAN EXPENSES	A	-189,025	Rural Health Clinic	88	46
47	PHYSICIAN EXPENSES	A	-611	RHC II	88.01	47
48	PHYSICIAN EXPENSES	A	-9,111	RHC III	88.02	48
49						49
49.01	NONALLOW CARELINK COST	A	-34,501	Home Health Agency	101	49.01
49.02	MISC INCOME	B	-11,786	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.02
49.03	AHA & IHA DUES	A	-15,583	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.03
49.04	OB LOCUM TENUMS	A	-11,500	Adults & Pediatrics	30	49.04
49.05	NONPATIENT CPR	B	-1,187	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.05
49.07	DONATIONS, PROJECTS	B	-61,202	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.07
49.12	CRNA FEES	A	-181,987	Operating Room	50	49.12
49.13	ADMIN CLAIMS FEES	A	74,400	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.13
49.15	PHYSICIAN FEES	A	-748,639	Clinic	90	49.15
49.16	CRNA	A	-574,812	Operating Room	50	49.16
49.17	CRNA	A	-43,727	Employee Benefits Department	4	49.17
49.18	NONALLOW ADS	A	-24,781	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.18

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION(1)		BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		Wkst. A-7 Ref.
				COST CENTER	LINE#	
		1	2	3	4	5
49.19	NONALLOW COST	A	-11,900	OTHER ADMINISTRATIVE AND GENERAL	5.06	49.19
49.20	MRI RENT	B	-900	Radiology-Diagnostic	54	49.20
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-5,799,476			50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

WORKSHEET A-8-1

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

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
1	2	3	4	5	6	7	
1						1	
2						2	
3						3	
4						4	
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12						5

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

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

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

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

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	65	Respiratory Therapy AGGREGATE	20,000	20,000						1
2	91	Emergency AGGREGATE	1,274,543	995,800	278,743					2
3	30	Adults & Pediatrics AGGREGATE	98,156	98,156						3
4	90	Clinic AGGREGATE	215,557	215,557						4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,608,256	1,329,513	278,743					200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	65	Respiratory Therapy AGGREGATE							20,000	1
2	91	Emergency AGGREGATE							995,800	2
3	30	Adults & Pediatrics AGGREGATE							98,156	3
4	90	Clinic AGGREGATE							215,557	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,329,513	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					260	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					912	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 visit(s)) (see instructions)						6
7	Standard travel expense rate					5.75	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		2,985.00				9
10	AHSEA (see instructions)		76.67				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	38.34	38.34				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)					228,860	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)					228,860	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)					228,860	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)					228,860	23

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

Standard Travel Allowance							
24	Therapists (line 3 times column 2, line 11)					9,968	24
25	Assistants (line 4 times column 3, line 11)						25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,968	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,495	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					11,463	28
Optional Travel Allowance and Optional Travel Expense							
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)						29
30	Assistants (column 3, line 10 times column 3, line 12)						30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						32
33	Standard travel allowance and standard travel expense (line 28)					11,463	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)					34,966	36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)					34,966	38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)					5,244	39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	Optional travel expense (line 8 times the sum of columns 1-3, line 13)						43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.							
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)					40,210	44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)						45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)						46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists 1	Assistants 2	Aides 3	Trainees 4	Total 5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56	100.00				100.00	47
48	Overtime rate (see instructions)	115.01					48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	11,501					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)	76.67					52
53	Overtime cost limitation (line 51 times line 52)	159,474					53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)	11,501					54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)	7,667					55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	3,834				3,834	56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	228,860	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	11,463	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)	40,210	59
60	Overtime allowance (from column 5, line 56)	3,834	60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	284,367	63
64	Total cost of outside supplier services (from provider records)	237,021	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,439,863	2,439,863					1
2	Cap Rel Costs-Mvble Equip	658,897		658,897				2
4	Employee Benefits Department	4,147,963	19,960	1,192	4,169,115			4
5.01	NONPATIENT TELEPHONES	32,505			6,435	38,940		5.01
5.02	DATA PROCESSING	972,618	19,153	167,483	47,341	288	1,206,883	5.02
5.03	PURCHASING RECEIVING AND STORES	202,004	50,959	3,340	38,206	575		5.03
5.04	ADMITTING	389,269	16,848	3,165	77,084	767		5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	663,721	27,865	7,176	68,056	959	760,698	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	2,550,556	207,432	10,082	134,551	1,439	446,185	5.06
7	Operation of Plant	1,609,626	189,570	10,025	99,544	767		7
8	Laundry & Linen Service	145,394	58,519	3,210	23,241	96		8
9	Housekeeping	496,281	19,084	2,207	82,394	96		9
10	Dietary	445,643	77,211	10,591	55,757	671		10
11	Cafeteria	260,292	45,312		58,054			11
13	Nursing Administration	772,688	24,362		166,967	575		13
14	Central Services & Supply							14
15	Pharmacy	800,669	29,225	47,159	135,731	959		15
16	Medical Records & Library	812,241	71,633	16,325	153,496	1,439		16
17	Social Service	42,598	1,152	208	9,505	192		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,100,282	245,991	69,325	424,153	4,316		30
43	Nursery	54,126	9,611		10,857	192		43
44	Skilled Nursing Facility	1,075,527		7,460	170,420	2,686		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,526,102	454,393	121,447	230,180	2,110		50
52	Delivery Room & Labor Room	103,093	28,833		20,678			52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,367,133	78,294	33,472	161,096	1,439		54
54.01	RADIOLOGY-ULTRASOUND	208,500	11,178	1,713				54.01
60	Laboratory	1,564,037	39,366	15,213	138,445	671		60
62	Whole Blood & Packed Red Blood Cells	149,504	2,535					62
65	Respiratory Therapy	543,680	26,505	20,056	89,528	480		65
66	Physical Therapy	1,104,155	231,010	8,832	182,195	671		66
69	Electrocardiology	26,692	6,269	851	5,625	192		69
71	Medical Supplies Charged to Patients	735,574	40,933					71
72	Impl. Dev. Charged to Patients	108,529	6,177					72
73	Drugs Charged to Patients	1,685,839						73
76	CARDIAC REHAB	38,140	70,343	3,968	8,712	192		76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,140,654		31,693	862,216	6,522		88
88.01	RHC II	424,564		860	64,211	671		88.01
88.02	RHC III	579,973		3,829	91,727	2,494		88.02
90	Clinic	1,416,417		30,814	204,960	4,891		90
91	Emergency	1,162,794	221,261	21,545	176,879	1,055		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	573,519		569	115,965	863		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	38,131,662	2,330,984	653,810	4,114,209	38,268	1,206,883	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		16,134					190
192	Physicians' Private Offices	292,468			26,896			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	84,215				480		194.01
194.02	FOUNDATION SERVICES	38,758	1,152		6,463	96		194.02
194.03	WELLNESS	109,378		5,087	21,547	96		194.03
194.04	RENTED SPACE		91,593					194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	38,656,481	2,439,863	658,897	4,169,115	38,940	1,206,883	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMINISTRATIVE 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	295,084						5.03
5.04	ADMITTING	1,249	488,382					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	312		1,528,787				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	3,747			3,353,992	3,353,992		5.06
7	Operation of Plant	7,494			1,917,026	182,131	2,099,157	7
8	Laundry & Linen Service	2,498			232,958	22,133	49,949	8
9	Housekeeping	9,680			609,742	57,930	16,289	9
10	Dietary	7,494			597,367	56,754	65,904	10
11	Cafeteria				363,658	34,550	38,677	11
13	Nursing Administration	937			965,529	91,732	20,794	13
14	Central Services & Supply							14
15	Pharmacy	2,810			1,016,553	96,580	24,945	15
16	Medical Records & Library	1,249			1,056,383	100,364	61,143	16
17	Social Service				53,655	5,098	984	17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,115	121,348	78,285	3,056,815	290,419	209,969	30
43	Nursery		11,140	6,283	92,209	8,761	8,204	43
44	Skilled Nursing Facility	5,308			1,261,401	119,842	214,159	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	30,289	75,855	258,584	2,698,960	256,420	387,852	50
52	Delivery Room & Labor Room		28,605	16,968	198,177	18,828	24,611	52
53	Anesthesiology							53
54	Radiology-Diagnostic	13,739	36,458	324,410	2,016,041	191,538	66,829	54
54.01	RADIOLOGY-ULTRASOUND		10,873	61,232	293,496	27,884	9,541	54.01
60	Laboratory	47,463	56,523	312,629	2,174,347	206,578	33,601	60
62	Whole Blood & Packed Red Blood Cells		6,536	8,583	167,158	15,881	2,164	62
65	Respiratory Therapy	7,806	24,452	35,558	748,065	71,071	22,624	65
66	Physical Therapy	2,186	23,306	77,781	1,630,136	154,874	197,181	66
69	Electrocardiology		2,791	13,636	56,056	5,326	5,351	69
71	Medical Supplies Charged to Patients	12,178	33,737	40,799	863,221	82,012	34,939	71
72	Impl. Dev. Charged to Patients	79,939	10,398	12,971	218,014	20,713	5,272	72
73	Drugs Charged to Patients		39,829	117,160	1,842,828	175,082		73
76	CARDIAC REHAB	312	12	3,769	125,448	11,918	60,042	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	14,676			5,055,761	480,339		88
88.01	RHC II	1,561			491,867	46,731		88.01
88.02	RHC III	2,810			680,833	64,684		88.02
90	Clinic	11,554	642	34,705	1,703,983	161,890	265,860	90
91	Emergency	4,684	5,877	106,529	1,700,624	161,571	188,860	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3,123		18,905	712,944	67,735		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	288,213	488,382	1,528,787	37,955,247	3,287,369	2,015,744	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				16,134	1,533	13,771	190
192	Physicians' Private Offices	3,123			322,487	30,639		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	625			85,320	8,106		194.01
194.02	FOUNDATION SERVICES	2,186			48,655	4,623	984	194.02
194.03	WELLNESS	937			137,045	13,020	68,658	194.03
194.04	RENTED SPACE				91,593	8,702		194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	295,084	488,382	1,528,787	38,656,481	3,353,992	2,099,157	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	Operation of Plant							7
8	Laundry & Linen Service	305,040						8
9	Housekeeping		683,961					9
10	Dietary	6,559	21,654	748,238				10
11	Cafeteria		12,708		449,593			11
13	Nursing Administration		6,832		17,841	1,102,728		13
14	Central Services & Supply							14
15	Pharmacy		8,196		12,489	63,684	1,222,447	15
16	Medical Records & Library		20,089		30,330			16
17	Social Service		323		1,784	9,716		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	113,682	68,988	257,331	62,443	330,528		30
43	Nursery	877	2,695		1,784	10,680		43
44	Skilled Nursing Facility	87,951	70,364	453,004	35,682	189,097		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	35,684	127,434	17,580	33,898	182,114		50
52	Delivery Room & Labor Room	3,328	8,086		3,568	20,336		52
53	Anesthesiology							53
54	Radiology-Diagnostic	16,981	21,957		21,409			54
54.01	RADIOLOGY-ULTRASOUND		3,135					54.01
60	Laboratory	98	11,040		19,625			60
62	Whole Blood & Packed Red Blood Cells		711					62
65	Respiratory Therapy	2,550	7,433		12,489	66,496		65
66	Physical Therapy		64,786		23,193			66
69	Electrocardiology		1,758					69
71	Medical Supplies Charged to Patients		11,480					71
72	Impl. Dev. Charged to Patients		1,732					72
73	Drugs Charged to Patients						1,222,447	73
76	CARDIAC REHAB		19,727					76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,049	87,564		89,206			88
88.01	RHC II	128						88.01
88.02	RHC III	145						88.02
90	Clinic	2,537			33,898			90
91	Emergency	30,006	62,052	20,323	26,761	145,933		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,909		16,057	84,144		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	302,575	643,653	748,238	442,457	1,102,728	1,222,447	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,525					190
192	Physicians' Private Offices							192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		12,902					194.01
194.02	FOUNDATION SERVICES		323		1,784			194.02
194.03	WELLNESS	2,465	22,558		5,352			194.03
194.04	RENTED SPACE							194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	305,040	683,961	748,238	449,593	1,102,728	1,222,447	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING RECEIVING AND STORES						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	1,268,309					16
17	Social Service		71,560				17
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	58,298	44,367	4,492,840		4,492,840	30
43	Nursery	5,436		130,646		130,646	43
44	Skilled Nursing Facility		18,606	2,450,106		2,450,106	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	223,723		3,963,665		3,963,665	50
52	Delivery Room & Labor Room	14,680		291,614		291,614	52
53	Anesthesiology						53
54	Radiology-Diagnostic	280,648		2,615,403		2,615,403	54
54.01	RADIOLOGY-ULTRASOUND	52,977		387,033		387,033	54.01
60	Laboratory	270,482		2,715,771		2,715,771	60
62	Whole Blood & Packed Red Blood Cells	7,426		193,340		193,340	62
65	Respiratory Therapy	30,765		961,493		961,493	65
66	Physical Therapy	67,295		2,137,465		2,137,465	66
69	Electrocardiology	11,798		80,289		80,289	69
71	Medical Supplies Charged to Patients	24,935		1,016,587		1,016,587	71
72	Impl. Dev. Charged to Patients	11,223		256,954		256,954	72
73	Drugs Charged to Patients	111,729		3,352,086		3,352,086	73
76	CARDIAC REHAB	3,261		220,396		220,396	76
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic			5,714,919		5,714,919	88
88.01	RHC II			538,726		538,726	88.01
88.02	RHC III			745,662		745,662	88.02
90	Clinic			2,168,168		2,168,168	90
91	Emergency	93,633	6,440	2,436,203		2,436,203	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		2,147	885,936		885,936	101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	1,268,309	71,560	37,755,302		37,755,302	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen			35,963		35,963	190
192	Physicians' Private Offices			353,126		353,126	192
194	NONREIMBURSEABLE						194
194.01	PROFESSIONAL BUILDINGS			106,328		106,328	194.01
194.02	FOUNDATION SERVICES			56,369		56,369	194.02
194.03	WELLNESS			249,098		249,098	194.03
194.04	RENTED SPACE			100,295		100,295	194.04
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	1,268,309	71,560	38,656,481		38,656,481	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	NONPATIENT TELEPHONE S 5.01	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		19,960	1,192	21,152	21,152		4
5.01	NONPATIENT TELEPHONES					33	33	5.01
5.02	DATA PROCESSING		19,153	167,483	186,636	240		5.02
5.03	PURCHASING RECEIVING AND STORES		50,959	3,340	54,299	194		5.03
5.04	ADMITTING		16,848	3,165	20,013	391	1	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		27,865	7,176	35,041	345	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		207,432	10,082	217,514	682	1	5.06
7	Operation of Plant		189,570	10,025	199,595	505	1	7
8	Laundry & Linen Service		58,519	3,210	61,729	118		8
9	Housekeeping		19,084	2,207	21,291	418		9
10	Dietary		77,211	10,591	87,802	283	1	10
11	Cafeteria		45,312		45,312	294		11
13	Nursing Administration		24,362		24,362	847		13
14	Central Services & Supply							14
15	Pharmacy		29,225	47,159	76,384	688	1	15
16	Medical Records & Library		71,633	16,325	87,958	779	1	16
17	Social Service		1,152	208	1,360	48		17
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	15,497	245,991	69,325	330,813	2,151	4	30
43	Nursery		9,611		9,611	55		43
44	Skilled Nursing Facility	10,516		7,460	17,976	864	2	44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room	50,155	454,393	121,447	625,995	1,167	2	50
52	Delivery Room & Labor Room		28,833		28,833	105		52
53	Anesthesiology							53
54	Radiology-Diagnostic		78,294	33,472	111,766	817	1	54
54.01	RADIOLOGY-ULTRASOUND		11,178	1,713	12,891			54.01
60	Laboratory		39,366	15,213	54,579	702	1	60
62	Whole Blood & Packed Red Blood Cells		2,535		2,535			62
65	Respiratory Therapy		26,505	20,056	46,561	454		65
66	Physical Therapy		231,010	8,832	239,842	924	1	66
69	Electrocardiology		6,269	851	7,120	29		69
71	Medical Supplies Charged to Patients		40,933		40,933			71
72	Impl. Dev. Charged to Patients		6,177		6,177			72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB		70,343	3,968	74,311	44		76
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic			31,693	31,693	4,381	6	88
88.01	RHC II			860	860	326	1	88.01
88.02	RHC III	12,600		3,829	16,429	465	2	88.02
90	Clinic			30,814	30,814	1,040	4	90
91	Emergency		221,261	21,545	242,806	897	1	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency			569	569	588	1	101
SPECIAL PURPOSE COST CENTERS								
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	88,768	2,330,984	653,810	3,073,562	20,874	33	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen		16,134		16,134			190
192	Physicians' Private Offices	1,500			1,500	136		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS							194.01
194.02	FOUNDATION SERVICES		1,152		1,152	33		194.02
194.03	WELLNESS			5,087	5,087	109		194.03
194.04	RENTED SPACE		91,593		91,593			194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	90,268	2,439,863	658,897	3,189,028	21,152	33	202

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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 GENERAL	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	186,876						5.02
5.03	PURCHASING RECEIVING AND STORES		54,493					5.03
5.04	ADMITTING			20,636				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	117,788	58		153,233			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	69,088	692			287,977		5.06
7	Operation of Plant		1,384			15,637	217,122	7
8	Laundry & Linen Service		461			1,900	5,166	8
9	Housekeeping		1,788			4,974	1,685	9
10	Dietary		1,384			4,873	6,817	10
11	Cafeteria					2,966	4,000	11
13	Nursing Administration		173			7,876	2,151	13
14	Central Services & Supply							14
15	Pharmacy		519			8,292	2,580	15
16	Medical Records & Library		231			8,617	6,324	16
17	Social Service					438	102	17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		2,422	5,131	7,845	24,934	21,718	30
43	Nursery			471	630	752	849	43
44	Skilled Nursing Facility		980			10,289	22,151	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,593	3,204	25,912	22,015	40,117	50
52	Delivery Room & Labor Room			1,208	1,700	1,617	2,546	52
53	Anesthesiology							53
54	Radiology-Diagnostic		2,537	1,540	32,546	16,445	6,912	54
54.01	RADIOLOGY-ULTRASOUND			459	6,136	2,394	987	54.01
60	Laboratory		8,765	2,388	31,328	17,736	3,475	60
62	Whole Blood & Packed Red Blood Cells			276	860	1,364	224	62
65	Respiratory Therapy		1,442	1,033	3,563	6,102	2,340	65
66	Physical Therapy		404	985	7,794	13,297	20,395	66
69	Electrocardiology			118	1,366	457	553	69
71	Medical Supplies Charged to Patients		2,249	1,425	4,088	7,041	3,614	71
72	Impl. Dev. Charged to Patients		14,760	439	1,300	1,778	545	72
73	Drugs Charged to Patients			1,683	11,740	15,032	73	73
76	CARDIAC REHAB		58	1	378	1,023	6,210	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		2,710			41,255		88
88.01	RHC II		288			4,012		88.01
88.02	RHC III		519			5,554		88.02
90	Clinic		2,134	27	3,478	13,899	27,499	90
91	Emergency		865	248	10,675	13,872	19,534	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		577		1,894	5,815		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	186,876	53,224	20,636	153,233	282,256	208,494	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					132	1,424	190
192	Physicians' Private Offices		577			2,631		192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		115			696		194.01
194.02	FOUNDATION SERVICES		404			397	102	194.02
194.03	WELLNESS		173			1,118	7,102	194.03
194.04	RENTED SPACE					747		194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	186,876	54,493	20,636	153,233	287,977	217,122	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	Operation of Plant							7
8	Laundry & Linen Service	69,374						8
9	Housekeeping		30,156					9
10	Dietary	1,492	955	103,607				10
11	Cafeteria		560		53,132			11
13	Nursing Administration		301		2,108	37,818		13
14	Central Services & Supply							14
15	Pharmacy		361		1,476	2,184	92,485	15
16	Medical Records & Library		886		3,584			16
17	Social Service		14		211	333		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	25,855	3,042	35,632	7,379	11,336		30
43	Nursery	199	119		211	366		43
44	Skilled Nursing Facility	20,002	3,102	62,727	4,217	6,485		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	8,115	5,619	2,434	4,006	6,246		50
52	Delivery Room & Labor Room	757	357		422	697		52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,862	968		2,530			54
54.01	RADIOLOGY-ULTRASOUND		138					54.01
60	Laboratory	22	487		2,319			60
62	Whole Blood & Packed Red Blood Cells		31					62
65	Respiratory Therapy	580	328		1,476	2,280		65
66	Physical Therapy		2,856		2,741			66
69	Electrocardiology		78					69
71	Medical Supplies Charged to Patients		506					71
72	Impl. Dev. Charged to Patients		76					72
73	Drugs Charged to Patients						92,485	73
76	CARDIAC REHAB		870					76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	466	3,861		10,541			88
88.01	RHC II	29						88.01
88.02	RHC III	33						88.02
90	Clinic	577			4,006			90
91	Emergency	6,824	2,736	2,814	3,163	5,005		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		128		1,898	2,886		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	68,813	28,379	103,607	52,288	37,818	92,485	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		199					190
192	Physicians' Private Offices							192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		569					194.01
194.02	FOUNDATION SERVICES		14		211			194.02
194.03	WELLNESS	561	995		633			194.03
194.04	RENTED SPACE							194.04
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	69,374	30,156	103,607	53,132	37,818	92,485	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		16	17	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING RECEIVING AND STORES						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	108,380					16
17	Social Service		2,506				17
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	4,982	1,553	484,797		484,797	30
43	Nursery	465		13,728		13,728	43
44	Skilled Nursing Facility		652	149,447		149,447	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	19,119		769,544		769,544	50
52	Delivery Room & Labor Room	1,255		39,497		39,497	52
53	Anesthesiology						53
54	Radiology-Diagnostic	23,975		203,899		203,899	54
54.01	RADIOLOGY-ULTRASOUND	4,527		27,532		27,532	54.01
60	Laboratory	23,115		144,917		144,917	60
62	Whole Blood & Packed Red Blood Cells	635		5,925		5,925	62
65	Respiratory Therapy	2,629		68,788		68,788	65
66	Physical Therapy	5,751		294,990		294,990	66
69	Electrocardiology	1,008		10,729		10,729	69
71	Medical Supplies Charged to Patients	2,131		61,987		61,987	71
72	Impl. Dev. Charged to Patients	959		26,034		26,034	72
73	Drugs Charged to Patients	9,548		130,488		130,488	73
76	CARDIAC REHAB	279		83,174		83,174	76
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic			94,913		94,913	88
88.01	RHC II			5,516		5,516	88.01
88.02	RHC III			23,002		23,002	88.02
90	Clinic			83,478		83,478	90
91	Emergency	8,002	226	317,668		317,668	91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		75	14,431		14,431	101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	108,380	2,506	3,054,484		3,054,484	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen			17,889		17,889	190
192	Physicians' Private Offices			4,844		4,844	192
194	NONREIMBURSEABLE						194
194.01	PROFESSIONAL BUILDINGS			1,380		1,380	194.01
194.02	FOUNDATION SERVICES			2,313		2,313	194.02
194.03	WELLNESS			15,778		15,778	194.03
194.04	RENTED SPACE			92,340		92,340	194.04
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	108,380	2,506	3,189,028		3,189,028	202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA 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	105,860						1
2	Cap Rel Costs-Mvble Equip		921,702					2
4	Employee Benefits Department	866	1,668	17,389,594				4
5.01	NONPATIENT TELEPHONES			26,842	406			5.01
5.02	DATA PROCESSING	831	234,284	197,460	3	10,000		5.02
5.03	PURCHASING RECEIVING AND STORES	2,211	4,672	159,360	6		945	5.03
5.04	ADMITTING	731	4,428	321,521	8		4	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,209	10,038	283,864	10	6,303	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,000	14,103	561,220	15	3,697	12	5.06
7	Operation of Plant	8,225	14,023	415,202	8		24	7
8	Laundry & Linen Service	2,539	4,491	96,938	1		8	8
9	Housekeeping	828	3,087	343,671	1		31	9
10	Dietary	3,350	14,815	232,564	7		24	10
11	Cafeteria	1,966		242,148				11
13	Nursing Administration	1,057		696,426	6		3	13
14	Central Services & Supply							14
15	Pharmacy	1,268	65,969	566,142	10		9	15
16	Medical Records & Library	3,108	22,837	640,238	15		4	16
17	Social Service	50	291	39,646	2			17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	10,673	96,976	1,769,162	45		42	30
43	Nursery	417		45,283	2			43
44	Skilled Nursing Facility		10,435	710,830	28		17	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,715	169,887	960,092	22		97	50
52	Deliverv Room & Labor Room	1,251		86,250				52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397	46,822	671,939	15		44	54
54.01	RADIOLOGY-ULTRASOUND	485	2,396					54.01
60	Laboratory	1,708	21,281	577,461	7		152	60
62	Whole Blood & Packed Red Blood Cells	110						62
65	Respiratory Therapy	1,150	28,055	373,427	5		25	65
66	Physical Therapy	10,023	12,355	759,943	7		7	66
69	Electrocardiology	272	1,191	23,463	2			69
71	Medical Supplies Charged to Patients	1,776					39	71
72	Impl. Dev. Charged to Patients	268					256	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	3,052	5,550	36,339	2		1	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		44,334	3,596,359	68		47	88
88.01	RHC II		1,203	267,828	7		5	88.01
88.02	RHC III		5,356	382,598	26		9	88.02
90	Clinic		43,104	854,899	51		37	90
91	Emergency	9,600	30,139	737,769	11		15	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		796	483,695	9		10	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	101,136	914,586	17,160,579	399	10,000	923	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices			112,183			10	192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				5		2	194.01
194.02	FOUNDATION SERVICES	50		26,957	1		7	194.02
194.03	WELLNESS		7,116	89,875	1		3	194.03
194.04	RENTED SPACE	3,974						194.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,439,863	658,897	4,169,115	38,940	1,206,883	295,084	202
203	Unit Cost Multiplier (Wkst. B, Part I)	23.048016	0.714870	0.239748	95.911330	120.688300	312.258201	203
204	Cost to be allocated (Per Wkst. B, Part II)			21,152	33	186,876	54,493	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001216	0.081281	18.687600	57.664550	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ADMITTING INPATIENT REVENUE	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	5A.06	5.06	7	8	
	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	13,997,071						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		77,686,338					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-3,353,992	35,302,489			5.06
7	Operation of Plant				1,917,026	106,703		7
8	Laundry & Linen Service				232,958	2,539	189,944	8
9	Housekeeping				609,742	828		9
10	Dietary				597,367	3,350	4,084	10
11	Cafeteria				363,658	1,966		11
13	Nursing Administration				965,529	1,057		13
14	Central Services & Supply							14
15	Pharmacy				1,016,553	1,268		15
16	Medical Records & Library				1,056,383	3,108		16
17	Social Service				53,655	50		17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,477,942	3,978,093		3,056,815	10,673	70,788	30
43	Nursery	319,267	319,267		92,209	417	546	43
44	Skilled Nursing Facility				1,261,401	10,886	54,766	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,174,004	13,140,102		2,698,960	19,715	22,220	50
52	Delivery Room & Labor Room	819,813	862,225		198,177	1,251	2,072	52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,044,884	16,485,133		2,016,041	3,397	10,574	54
54.01	RADIOLOGY-ULTRASOUND	311,633	3,111,547		293,496	485		54.01
60	Laboratory	1,619,947	15,886,413		2,174,347	1,708	61	60
62	Whole Blood & Packed Red Blood Cells	187,311	436,161		167,158	110		62
65	Respiratory Therapy	700,777	1,806,920		748,065	1,150	1,588	65
66	Physical Therapy	667,933	3,952,505		1,630,136	10,023		66
69	Electrocardiology	79,978	692,936		56,056	272		69
71	Medical Supplies Charged to Patients	966,892	2,073,241		863,221	1,776		71
72	Impl. Dev. Charged to Patients	298,018	659,154		218,014	268		72
73	Drugs Charged to Patients	1,141,496	5,953,539		1,842,828			73
76	CARDIAC REHAB	342	191,508		125,448	3,052		76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				5,055,761		1,276	88
88.01	RHC II				491,867		80	88.01
88.02	RHC III				680,833		90	88.02
90	Clinic	18,387	1,763,578		1,703,983	13,514	1,580	90
91	Emergency	168,447	5,413,349		1,700,624	9,600	18,684	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		960,667		712,944			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	13,997,071	77,686,338	-3,353,992	34,601,255	102,463	188,409	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				16,134	700		190
192	Physicians' Private Offices				322,487			192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS				85,320			194.01
194.02	FOUNDATION SERVICES				48,655	50		194.02
194.03	WELLNESS				137,045	3,490	1,535	194.03
194.04	RENTED SPACE				91,593			194.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	488,382	1,528,787		3,353,992	2,099,157	305,040	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.034892	0.019679		0.095007	19.672896	1.605947	203
204	Cost to be allocated (Per Wkst. B, Part II)	20,636	153,233		287,977	217,122	69,374	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.001474	0.001972		0.008157	2.034826	0.365234	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINISTRATION NURSING HOURS	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	105,815						9
10	Dietary	3,350	46,648					10
11	Cafeteria	1,966		252				11
13	Nursing Administration	1,057		10	240,377			13
14	Central Services & Supply							14
15	Pharmacy	1,268		7	13,882	1,668,160		15
16	Medical Records & Library	3,108		17			74,494,109	16
17	Social Service	50		1	2,118			17
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	10,673	16,043	35	72,050		3,424,032	30
43	Nursery	417		1	2,328		319,267	43
44	Skilled Nursing Facility	10,886	28,242	20	41,220			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	19,715	1,096	19	39,698		13,140,101	50
52	Delivery Room & Labor Room	1,251		2	4,433		862,225	52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397		12			16,485,133	54
54.01	RADIOLOGY-ULTRASOUND	485					3,111,547	54.01
60	Laboratory	1,708		11			15,886,413	60
62	Whole Blood & Packed Red Blood Cells	110					436,161	62
65	Respiratory Therapy	1,150		7	14,495		1,806,920	65
66	Physical Therapy	10,023		13			3,952,505	66
69	Electrocardiology	272					692,936	69
71	Medical Supplies Charged to Patients	1,776					1,464,541	71
72	Impl. Dev. Charged to Patients	268					659,155	72
73	Drugs Charged to Patients					1,668,160	6,562,239	73
76	CARDIAC REHAB	3,052					191,508	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	13,547		50				88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic			19				90
91	Emergency	9,600	1,267	15	31,811		5,499,426	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	450		9	18,342			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	99,579	46,648	248	240,377	1,668,160	74,494,109	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices							192
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	1,996						194.01
194.02	FOUNDATION SERVICES	50		1				194.02
194.03	WELLNESS	3,490		3				194.03
194.04	RENTED SPACE							194.04
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	683,961	748,238	449,593	1,102,728	1,222,447	1,268,309	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.463743	16.040087	1,784.099206	4.587494	0.732812	0.017026	203
204	Cost to be allocated (Per Wkst. B, Part II)	30,156	103,607	53,132	37,818	92,485	108,380	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.284988	2.221038	210.841270	0.157328	0.055441	0.001455	205

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME						
	17						

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING RECEIVING AND STORES						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service	100					17
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	62					30
43	Nursery						43
44	Skilled Nursing Facility	26					44
ANCILLARY SERVICE COST CENTERS							
50	Operating Room						50
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
54.01	RADIOLOGY-ULTRASOUND						54.01
60	Laboratory						60
62	Whole Blood & Packed Red Blood Cells						62
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76	CARDIAC REHAB						76
OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic						88
88.01	RHC II						88.01
88.02	RHC III						88.02
90	Clinic						90
91	Emergency	9					91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	3					101
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100					118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
194	NONREIMBURSEABLE						194
194.01	PROFESSIONAL BUILDINGS						194.01
194.02	FOUNDATION SERVICES						194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	71,560					202
203	Unit Cost Multiplier (Wkst. B, Part I)	715.600000					203
204	Cost to be allocated (Per Wkst. B, Part II)	2,506					204
205	Unit Cost Multiplier (Wkst. B, Part II)	25.060000					205

Optimizer Systems, Inc.

WinLASH System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		PART	LINE NO.		
	1	2	3	4	

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	COSTS			
				Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,492,840		4,492,840		4,492,840	30
43	Nursery	130,646		130,646		130,646	43
44	Skilled Nursing Facility	2,450,106		2,450,106		2,450,106	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	3,963,665		3,963,665		3,963,665	50
52	Delivery Room & Labor Room	291,614		291,614		291,614	52
53	Anesthesiology						53
54	Radiology-Diagnostic	2,615,403		2,615,403		2,615,403	54
54.01	RADIOLOGY-ULTRASOUND	387,033		387,033		387,033	54.01
60	Laboratory	2,715,771		2,715,771		2,715,771	60
62	Whole Blood & Packed Red Blood Cells	193,340		193,340		193,340	62
65	Respiratory Therapy	961,493		961,493		961,493	65
66	Physical Therapy	2,137,465		2,137,465		2,137,465	66
69	Electrocardiology	80,289		80,289		80,289	69
71	Medical Supplies Charged to Patients	1,016,587		1,016,587		1,016,587	71
72	Impl. Dev. Charged to Patients	256,954		256,954		256,954	72
73	Drugs Charged to Patients	3,352,086		3,352,086		3,352,086	73
76	CARDIAC REHAB	220,396		220,396		220,396	76
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	5,714,919		5,714,919		5,714,919	88
88.01	RHC II	538,726		538,726		538,726	88.01
88.02	RHC III	745,662		745,662		745,662	88.02
90	Clinic	2,168,168		2,168,168		2,168,168	90
91	Emergency	2,436,203		2,436,203		2,436,203	91
92	Observation Beds (Non-Distinct Part)	517,821		517,821		517,821	92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	885,936		885,936		885,936	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	38,273,123		38,273,123		38,273,123	200
201	Less Observation Beds	517,821		517,821		517,821	201
202	Total (line 200 minus line 201)	37,755,302		37,755,302		37,755,302	202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	3,461,614		3,461,614				30
43	Nursery	319,267		319,267				43
44	Skilled Nursing Facility	1,333,042		1,333,042				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,174,004	10,966,098	13,140,102	0.301646	0.301646	0.301646	50
52	Delivery Room & Labor Room	819,813	42,412	862,225	0.338211	0.338211	0.338211	52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,044,884	15,440,249	16,485,133	0.158652	0.158652	0.158652	54
54.01	RADIOLOGY-ULTRASOUND	311,633	2,799,914	3,111,547	0.124386	0.124386	0.124386	54.01
60	Laboratory	1,619,947	14,266,466	15,886,413	0.170949	0.170949	0.170949	60
62	Whole Blood & Packed Red Blood Cells	187,311	248,850	436,161	0.443277	0.443277	0.443277	62
65	Respiratory Therapy	700,777	1,106,143	1,806,920	0.532117	0.532117	0.532117	65
66	Physical Therapy	667,933	3,284,571	3,952,504	0.540788	0.540788	0.540788	66
69	Electrocardiology	79,978	612,958	692,936	0.115868	0.115868	0.115868	69
71	Medical Supplies Charged to Patients	966,892	1,106,349	2,073,241	0.490337	0.490337	0.490337	71
72	Impl. Dev. Charged to Patients	298,018	361,136	659,154	0.389824	0.389824	0.389824	72
73	Drugs Charged to Patients	1,141,496	4,812,043	5,953,539	0.563041	0.563041	0.563041	73
76	CARDIAC REHAB	342	191,166	191,508	1.150845	1.150845	1.150845	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		5,842,014	5,842,014				88
88.01	RHC II		606,628	606,628				88.01
88.02	RHC III		799,676	799,676				88.02
90	Clinic	18,387	1,745,191	1,763,578	1.229414	1.229414	1.229414	90
91	Emergency	168,447	5,244,902	5,413,349	0.450036	0.450036	0.450036	91
92	Observation Beds (Non-Distinct Part)	16,328	500,151	516,479	1.002598	1.002598	1.002598	92
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		960,667	960,667				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	15,330,113	70,937,584	86,267,697				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	15,330,113	70,937,584	86,267,697				202

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1343

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.301646		2,822,818			851,492	50
52	Delivery Room & Labor Room	0.338211						52
53	Anesthesiology							53
54	Radiology-Diagnostic	0.158652		5,482,527			869,814	54
54.01	RADIOLOGY-ULTRASOUND	0.124386		870,096			108,228	54.01
60	Laboratory	0.170949		6,012,244			1,027,787	60
62	Whole Blood & Packed Red Blood Cells	0.443277		248,850			110,309	62
65	Respiratory Therapy	0.532117		368,793			196,241	65
66	Physical Therapy	0.540788		916,425			495,592	66
69	Electrocardiology	0.115868		283,710			32,873	69
71	Medical Supplies Charged to Patients	0.490337		226,126			110,878	71
72	Impl. Dev. Charged to Patients	0.389824		166,370			64,855	72
73	Drugs Charged to Patients	0.563041		3,096,955			1,743,713	73
76	CARDIAC REHAB	1.150845		44,363			51,055	76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic	1.229414		722,890			888,731	90
91	Emergency	0.450036		1,672,705			752,777	91
92	Observation Beds (Non-Distinct Part)	1.002598		245,660			246,298	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)			23,180,532			7,550,643	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)			23,180,532			7,550,643	202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z343

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.301646						50
52	Delivery Room & Labor Room	0.338211						52
53	Anesthesiology							53
54	Radiology-Diagnostic	0.158652						54
54.01	RADIOLOGY-ULTRASOUND	0.124386						54.01
60	Laboratory	0.170949						60
62	Whole Blood & Packed Red Blood Cells	0.443277						62
65	Respiratory Therapy	0.532117						65
66	Physical Therapy	0.540788						66
69	Electrocardiology	0.115868						69
71	Medical Supplies Charged to Patients	0.490337						71
72	Impl. Dev. Charged to Patients	0.389824						72
73	Drugs Charged to Patients	0.563041						73
76	CARDIAC REHAB	1.150845						76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic	1.229414						90
91	Emergency	0.450036						91
92	Observation Beds (Non-Distinct Part)	1.002598						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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-6150

WORKSHEET D
PART IV

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

(A)	Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
		1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-6150

WORKSHEET D
PART IV

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	13,140,102							50
52	Delivery Room & Labor Room	862,225							52
53	Anesthesiology								53
54	Radiology-Diagnostic	16,485,133			50,484				54
54.01	RADIOLOGY-ULTRASOUND	3,111,547			5,664				54.01
60	Laboratory	15,886,413			67,871				60
62	Whole Blood & Packed Red Blood Cells	436,161			1,911				62
65	Respiratory Therapy	1,806,920			22,121				65
66	Physical Therapy	3,952,504			401,786				66
69	Electrocardiology	692,936			1,694				69
71	Medical Supplies Charged to Patients	2,073,241			6,950				71
72	Impl. Dev. Charged to Patients	659,154							72
73	Drugs Charged to Patients	5,953,539			17,682				73
76	CARDIAC REHAB	191,508							76
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic	5,842,014							88
88.01	RHC II	606,628							88.01
88.02	RHC III	799,676							88.02
90	Clinic	1,763,578							90
91	Emergency	5,413,349							91
92	Observation Beds (Non-Distinct Part)	516,479							92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	80,193,107			576,163				200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-6150

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost		
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.301646						50
52	Delivery Room & Labor Room	0.338211						52
53	Anesthesiology							53
54	Radiology-Diagnostic	0.158652						54
54.01	RADIOLOGY-ULTRASOUND	0.124386						54.01
60	Laboratory	0.170949						60
62	Whole Blood & Packed Red Blood Cells	0.443277						62
65	Respiratory Therapy	0.532117						65
66	Physical Therapy	0.540788						66
69	Electrocardiology	0.115868						69
71	Medical Supplies Charged to Patients	0.490337						71
72	Impl. Dev. Charged to Patients	0.389824						72
73	Drugs Charged to Patients	0.563041						73
76	CARDIAC REHAB	1.150845						76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic	1.229414						90
91	Emergency	0.450036						91
92	Observation Beds (Non-Distinct Part)	1.002598						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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 + col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
1	2	3	4	5	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	484,797	28,642	456,155	3,886	117.38	466	54,699	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	13,728		13,728	303	45.31	207	9,379	43
44	Skilled Nursing Facility	149,447		149,447	7,912	18.89			44
45	Nursing Facility								45
200	Total (lines 30-199)	647,972		619,330	12,101		673	64,078	200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1343

WORKSHEET D
PART II

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

(A)	Cost Center Description	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)	
1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	769,544	13,140,102	0.058565	702,596	41,148	50
52	Delivery Room & Labor Room	39,497	862,225	0.045808	377,537	17,294	52
53	Anesthesiology						53
54	Radiology-Diagnostic	203,899	16,485,133	0.012369	170,412	2,108	54
54.01	RADIOLOGY-ULTRASOUND	27,532	3,111,547	0.008848	49,728	440	54.01
60	Laboratory	144,917	15,886,413	0.009122	343,093	3,130	60
62	Whole Blood & Packed Red Blood Cells	5,925	436,161	0.013584			62
65	Respiratory Therapy	68,788	1,806,920	0.038069	68,721	2,616	65
66	Physical Therapy	294,990	3,952,504	0.074634	4,388	327	66
69	Electrocardiology	10,729	692,936	0.015483	9,225	143	69
71	Medical Supplies Charged to Patients	61,987	2,073,241	0.029899	144,675	4,326	71
72	Impl. Dev. Charged to Patients	26,034	659,154	0.039496	13,485	533	72
73	Drugs Charged to Patients	130,488	5,953,539	0.021918	220,176	4,826	73
76	CARDIAC REHAB	83,174	191,508	0.434311			76
OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	94,913	5,842,014	0.016247			88
88.01	RHC II	5,516	606,628	0.009093			88.01
88.02	RHC III	23,002	799,676	0.028764			88.02
90	Clinic	83,478	1,763,578	0.047334	2,441	116	90
91	Emergency	317,668	5,413,349	0.058682	79,108	4,642	91
92	Observation Beds (Non-Distinct Part)	59,384	516,479	0.114979	6,518	749	92
OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	2,451,465	80,193,107		2,192,103	82,398	200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

		Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	3,886		466		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	303		207		43
44	Skilled Nursing Facility	7,912				44
45	Nursing Facility					45
200	Total (lines 30-199)	12,101		673		200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1343

WORKSHEET D
PART IV

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

(A)	Cost Center Description	1	2	3	4	5	6
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
54.01	RADIOLOGY-ULTRASOUND						54.01
60	Laboratory						60
62	Whole Blood & Packed Red Blood Cells						62
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76	CARDIAC REHAB						76
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic						88
88.01	RHC II						88.01
88.02	RHC III						88.02
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)						200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1343

WORKSHEET D
PART IV

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5+ col. 7)	Outpatient Ratio of Cost to Charges (col. 6+ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	13,140,102			702,596			50
52	Delivery Room & Labor Room	862,225			377,537			52
53	Anesthesiology							53
54	Radiology-Diagnostic	16,485,133			170,412			54
54.01	RADIOLOGY-ULTRASOUND	3,111,547			49,728			54.01
60	Laboratory	15,886,413			343,093			60
62	Whole Blood & Packed Red Blood Cells	436,161						62
65	Respiratory Therapy	1,806,920			68,721			65
66	Physical Therapy	3,952,504			4,388			66
69	Electrocardiology	692,936			9,225			69
71	Medical Supplies Charged to Patients	2,073,241			144,675			71
72	Impl. Dev. Charged to Patients	659,154			13,485			72
73	Drugs Charged to Patients	5,953,539			220,176			73
76	CARDIAC REHAB	191,508						76
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	5,842,014						88
88.01	RHC II	606,628						88.01
88.02	RHC III	799,676						88.02
90	Clinic	1,763,578			2,441			90
91	Emergency	5,413,349			79,108			91
92	Observation Beds (Non-Distinct Part)	516,479			6,518			92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	80,193,107			2,192,103			200

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1343

WORKSHEET D
PART V

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

(A)	Cost Center Description	Cost to Charge Ratio (from Wkst C, Part I, col. 9)	Program Charges			Program Cost			
			PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
1	2	3	4	5	6	7			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	0.301646		3,166,272		955,093		50	
52	Delivery Room & Labor Room	0.338211		42,412		14,344		52	
53	Anesthesiology							53	
54	Radiology-Diagnostic	0.158652		3,876,308		614,984		54	
54.01	RADIOLOGY-ULTRASOUND	0.124386		834,749		103,831		54.01	
60	Laboratory	0.170949		2,886,870		493,508		60	
62	Whole Blood & Packed Red Blood Cells	0.443277						62	
65	Respiratory Therapy	0.532117		216,169		115,027		65	
66	Physical Therapy	0.540788		610,542		330,174		66	
69	Electrocardiology	0.115868		218,140		25,275		69	
71	Medical Supplies Charged to Patients	0.490337		349,097		171,175		71	
72	Impl. Dev. Charged to Patients	0.389824		53,477		20,847		72	
73	Drugs Charged to Patients	0.563041		472,524		266,050		73	
76	CARDIAC REHAB	1.150845		6,104		7,025		76	
OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic							88	
88.01	RHC II							88.01	
88.02	RHC III							88.02	
90	Clinic	1.229414		284,441		349,696		90	
91	Emergency	0.450036		1,899,303		854,755		91	
92	Observation Beds (Non-Distinct Part)	1.002598		117,716		118,022		92	
OTHER REIMBURSABLE COST CENTERS									
200	Subtotal (see instructions)			15,034,124		4,439,806		200	
201	Less PBP Clinic Lab. Services-Program Only Charges							201	
202	Net Charges (line 200 - line 201)			15,034,124		4,439,806		202	

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,130	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,886	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,410	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	163	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)	81	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)	1,953	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)	163	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)	81	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	127.08	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20
21	Total general inpatient routine service cost (see instructions)	4,492,840	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)	265,435	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,227,405	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,227,405	37

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,087.85	38
39	Program general inpatient routine service cost (line 9 x line 38)						2,124,571	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)						2,124,571	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)						1,774,445	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						3,899,016	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 enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						177,320	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						88,116	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						265,436	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					476	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,087.86	88
89	Observation bed cost (line 87 x line 88) (see instructions)					517,821	89
		Cost	Routine Cost (from line 27)	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	484,797	4,227,405	0.114680	517,821	59,384	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-6150

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,912	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,912	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)	7,912	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)	1,479	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)	2,450,106	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)	2,450,106	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)	2,450,106	37

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-6150

WORKSHEET D-1
PARTS III & IV

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

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

70	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	2,450,106	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	309.67	71
72	Program routine service cost (line 9 x line 71)	458,002	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)	458,002	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)	458,002	83
84	Program inpatient ancillary services (see instructions)	263,775	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	721,777	86

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,130	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,886	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,410	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	163	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)	81	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)	466	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)	303	15
16	Nursery days (title V or XIX only)	207	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	127.08	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20
21	Total general inpatient routine service cost (see instructions)	4,492,840	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)	265,435	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,227,405	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,227,405	37

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1
PART II

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,087.85	38
39	Program general inpatient routine service cost (line 9 x line 38)					506,938	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)					506,938	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)	130,646	303	431.17	207	89,252	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)					716,806	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,312,996	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					64,078	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					82,398	51
52	Total Program excludable cost (sum of lines 50 and 51)					146,476	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					1,166,520	53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					476	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1343

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,946,871		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.301646	918,637	277,103	50
52	Delivery Room & Labor Room	0.338211			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.158652	687,125	109,014	54
54.01	RADIOLOGY-ULTRASOUND	0.124386	204,073	25,384	54.01
60	Laboratory	0.170949	1,044,976	178,638	60
62	Whole Blood & Packed Red Blood Cells	0.443277	172,752	76,577	62
65	Respiratory Therapy	0.532117	429,174	228,371	65
66	Physical Therapy	0.540788	176,043	95,202	66
69	Electrocardiology	0.115868	61,222	7,094	69
71	Medical Supplies Charged to Patients	0.490337	634,373	311,057	71
72	Impl. Dev. Charged to Patients	0.389824	246,823	96,218	72
73	Drugs Charged to Patients	0.563041	617,936	347,923	73
76	CARDIAC REHAB	1.150845			76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.229414	15,877	19,519	90
91	Emergency	0.450036	2,279	1,026	91
92	Observation Beds (Non-Distinct Part)	1.002598	1,316	1,319	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		5,212,606	1,774,445	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		5,212,606		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z343

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.301646			50
52	Delivery Room & Labor Room	0.338211			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.158652	20,879	3,312	54
54.01	RADIOLOGY-ULTRASOUND	0.124386	2,930	364	54.01
60	Laboratory	0.170949	34,804	5,950	60
62	Whole Blood & Packed Red Blood Cells	0.443277	559	248	62
65	Respiratory Therapy	0.532117	25,664	13,656	65
66	Physical Therapy	0.540788	85,716	46,354	66
69	Electrocardiology	0.115868	1,452	168	69
71	Medical Supplies Charged to Patients	0.490337	38,070	18,667	71
72	Impl. Dev. Charged to Patients	0.389824			72
73	Drugs Charged to Patients	0.563041	42,891	24,149	73
76	CARDIAC REHAB	1.150845			76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.229414	69	85	90
91	Emergency	0.450036			91
92	Observation Beds (Non-Distinct Part)	1.002598			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		253,034	112,953	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		253,034		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-6150

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICP/MR Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.301646			50
52	Delivery Room & Labor Room	0.338211			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.158652	50,484	8,009	54
54.01	RADIOLOGY-ULTRASOUND	0.124386	5,664	705	54.01
60	Laboratory	0.170949	67,871	11,602	60
62	Whole Blood & Packed Red Blood Cells	0.443277	1,911	847	62
65	Respiratory Therapy	0.532117	22,121	11,771	65
66	Physical Therapy	0.540788	401,786	217,281	66
69	Electrocardiology	0.115868	1,694	196	69
71	Medical Supplies Charged to Patients	0.490337	6,950	3,408	71
72	Impl. Dev. Charged to Patients	0.389824			72
73	Drugs Charged to Patients	0.563041	17,682	9,956	73
76	CARDIAC REHAB	1.150845			76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.229414			90
91	Emergency	0.450036			91
92	Observation Beds (Non-Distinct Part)	1.002598			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		576,163	263,775	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		576,163		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1343

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		519,171		30
43	Nursery		169,649		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.301646	702,596	211,935	50
52	Delivery Room & Labor Room	0.338211	377,537	127,687	52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.158652	170,412	27,036	54
54.01	RADIOLOGY-ULTRASOUND	0.124386	49,728	6,185	54.01
60	Laboratory	0.170949	343,093	58,651	60
62	Whole Blood & Packed Red Blood Cells	0.443277			62
65	Respiratory Therapy	0.532117	68,721	36,568	65
66	Physical Therapy	0.540788	4,388	2,373	66
69	Electrocardiology	0.115868	9,225	1,069	69
71	Medical Supplies Charged to Patients	0.490337	144,675	70,940	71
72	Impl. Dev. Charged to Patients	0.389824	13,485	5,257	72
73	Drugs Charged to Patients	0.563041	220,176	123,968	73
76	CARDIAC REHAB	1.150845			76
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.229414	2,441	3,001	90
91	Emergency	0.450036	79,108	35,601	91
92	Observation Beds (Non-Distinct Part)	1.002598	6,518	6,535	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,192,103	716,806	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,192,103		202

(A) Worksheet A line numbers

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1343

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	7,550,643			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	7,550,643			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 reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	7,626,149			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	95,469			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,470,209			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)	4,060,471			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)	4,060,471			30
31	Primary payer payments	439			31
32	Subtotal (line 30 minus line 31)	4,060,032			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)	473,045			34
35	Adjusted reimbursable bad debts (see instructions)	359,514			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	339,229			36
37	Subtotal (see instructions)	4,419,546			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)	4,419,546			40
40.01	Sequestration adjustment (see instructions)	88,391			40.01
41	Interim payments	4,658,800			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-327,645			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 (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-6150

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1343

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

DESCRIPTION	INPATIENT PART A		PART B		
	mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	1	2	3	4	
1 Total interim payments paid to provider		3,079,252		4,672,311	1
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	.01	04/16/2015			3.01
	.02				3.02
	Program				3.03
	to				3.04
	Provider				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.10				3.10
	.50		04/16/2015	13,511	3.50
	.51				3.51
	Provider				3.52
	to				3.53
	Program				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	31,703		-13,511	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)		3,110,955		4,658,800	4
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	.01				5.01
	.02				5.02
	Program				5.03
	to				5.04
	Provider				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	.10				5.10
	.50				5.50
	.51				5.51
	Provider				5.52
	to				5.53
	Program				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6 Determined net settlement amount (balance due) based on the cost report (1)	.01	373,917			6.01
	.02			-239,254	6.02
7 Total Medicare program liability (see instructions)		3,484,872		4,419,546	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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z343

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		313,245		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01	04/16/2015	6,534	3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		6,534	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)			319,779	4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		61,835	6.01
		.02			6.02
7	Total Medicare program liability (see instructions)			381,614	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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-6150

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
Applicable IPF SNF
Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		356,989		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	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)		356,989		4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		7,286		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		364,275		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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	947	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,953	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)		3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	3,410	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	86,267,697	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	2,102,797	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z343

WORKSHEET E-2

Check Title V Swing Bed - SNF
 Applicable Title XVIII Swing Bed - NF
 Boxes: Title XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	268,090		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. 5 and 7, line 202 for Part B) (For CAH, see instructions)	114,083		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	244		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)	382,173		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	382,173		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	559		11
12	Subtotal (line 10 minus line 11)	381,614		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)			13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	381,614		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	381,614		19
19.01	Sequestration adjustment (see instructions)	7,632		19.01
20	Interim payments	319,779		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	54,203		22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2			23

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART V

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

1	Inpatient services	3,899,016	1
2	Nursing an dalled health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	3,899,016	4
5	Primary payer payments		5
6	Total cost (line 4 less line 5) (see instructions)	3,938,006	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)	3,938,006	19
20	Deductibles (exclude professional component)	503,574	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	3,434,432	22
23	Coinsurance	608	23
24	Subtotal (line 22 minus line 23)	3,433,824	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	67,168	25
26	Adjusted reimbursable bad debts (see instructions)	51,048	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,969	27
28	Subtotal (sum of lines 24 and 26)	3,484,872	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	3,484,872	30
30.01	Sequestration adjustment (see instructions)	69,697	30.01
31	Interim payments	3,110,955	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	304,220	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3
PART VI

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

PROSPECTIVE PAYMENT AMOUNT (see instructions)		
1	Resource Utilization Group (RUGS) payment	474,036 1
2	Routine service other pass through costs	2
3	Ancillary service other pass through costs	3
4	Subtotal (sum of lines 1-3)	474,036 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	109,761 7
8	Allowable bad debts (see instructions)	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	9
10	Adjusted reimbursable bad debts (see instructions)	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)	364,275 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)	364,275 15
15.01	Sequestration adjustment (see instructions)	7,286 15.01
16	Interim payments	356,989 16
17	Tentative settlement (for contractor use only)	17
18	Balance due provider/program (line 15 minus lines 15.01, 16 and 17)	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	19

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1343

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable Title XIX SUB (Other) ICF/MR TEFRA
 Boxes: SNF Other

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services			1
2	Medical and other services		4,439,806	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)		4,439,806	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)		4,439,806	7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	Routine service charges	688,820		8
9	Ancillary service charges	2,192,103	15,034,124	9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)	2,880,923	15,034,124	12
CUSTOMARY CHARGES				
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	2,880,923	15,034,124	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)		4,439,806	21
PROSPECTIVE PAYMENT AMOUNT				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)		4,439,806	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		4,439,806	31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		4,439,806	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)		4,439,806	38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)		4,439,806	40
41	Interim payments		4,439,806	41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	11,179,052				1
2	Temporary investments	937,048				2
3	Notes receivable					3
4	Accounts receivable	9,674,446				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-2,780,000				6
7	Inventory	1,075,318				7
8	Prepaid expenses	597,386				8
9	Other current assets	255,285				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	20,938,535				11
FIXED ASSETS						
12	Land	290,645				12
13	Land improvements	1,310,228				13
14	Accumulated depreciation	-696,840				14
15	Buildings	48,637,302				15
16	Accumulated depreciation	-19,002,366				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,074,641				23
24	Accumulated depreciation	-9,328,117				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	982,181				27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	33,267,674				30
OTHER ASSETS						
31	Investments	14,197,759				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	334,097				34
35	Total other assets (sum of lines 31-34)	14,531,856				35
36	Total assets (sum of lines 11, 30 and 35)	68,738,065				36
Liabilities and Fund Balances						
	(Omit Cents)	1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	1,425,069				37
38	Salaries, wages and fees payable	3,092,448				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	872,503				40
41	Deferred income	44,472				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,581,625				44
45	Total current liabilities (sum of lines 37 thru 44)	7,016,117				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	13,812,000				47
48	Unsecured loans					48
49	Other long term liabilities	78,493				49
50	Total long term liabilities (sum of lines 46 thru 49)	13,890,493				50
51	Total liabilities (sum of lines 45 and 50)	20,906,610				51
CAPITAL ACCOUNTS						
52	General fund balance	47,831,455				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)	47,831,455				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	68,738,065				60

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		42,852,706			1
2	Net income (loss) (from Worksheet G-3, line 29)		4,978,749			2
3	Total (sum of line 1 and line 2)		47,831,455			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)		47,831,455			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		47,831,455			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,173,719		3,173,719	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	117,553		117,553	5
6	Swing Bed - NF				6
7	Skilled nursing facility	1,333,042		1,333,042	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	4,624,314		4,624,314	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	4,624,314		4,624,314	17
18	Ancillary services	11,978,591	56,092,014	68,070,605	18
19	Outpatient services		16,967,130	16,967,130	19
20	Rural Health Clinic (RHC)		6,374,447	6,374,447	20
20.01	RHC II		606,628	606,628	20.01
20.02	RHC III		267,243	267,243	20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		960,667	960,667	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN PRIVATE OFFICE		375,906	375,906	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	16,602,905	81,644,035	98,246,940	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		44,455,957	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		44,455,957	43

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	98,246,940	1
2	Less contractual allowances and discounts on patients' accounts	50,601,709	2
3	Net patient revenues (line 1 minus line 2)	47,645,231	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	44,455,957	4
5	Net income from service to patients (line 3 minus line 4)	3,189,274	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	119,695	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	203,715	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	2,266	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 hospial space	202,565	22
23	Governmental appropriations	273,480	23
24	Other (CONSULTING CLINIC)	80,059	24
24.01	Other (WELLNESS)	76,794	24.01
24.02	Other (GRANTS)	26,226	24.02
24.03	Other (OTHER PROFESSIONAL INCOME)	416,449	24.03
24.04	Other (FOUNDATION REIMBURSEMENT)	13,211	24.04
24.05	Other (DONATIONS)	17,285	24.05
24.06	Other (OTHER INCOME)	357,730	24.06
25	Total other income (sum of lines 6-24)	1,789,475	25
26	Total (line 5 plus line 25)	4,978,749	26
29	Net income (or loss) for the period (line 26 minus line 28)	4,978,749	29

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7175

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	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	106,591	6,928	1,593	30,959	39,282	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	270,428	17,579	17,381			6
7	Physical Therapy	38,836	2,524	4,652	3,624		7
8	Occupational Therapy	10,129	658	1,353			8
9	Speech Pathology	1,545		590			9
10	Medical Social Services						10
11	Home Health Aide	56,166	3,651	7,619			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)	483,695	31,340	33,188	34,583	39,282	24

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7175

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	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	185,353	-13,874	171,479	-34,695	136,784	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	305,388		305,388		305,388	6
7	Physical Therapy	49,636		49,636		49,636	7
8	Occupational Therapy	12,140		12,140		12,140	8
9	Speech Pathology	2,135		2,135		2,135	9
10	Medical Social Services						10
11	Home Health Aide	67,436		67,436		67,436	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)	622,088	-13,874	608,214	-34,695	573,519	24

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

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7175

WORKSHEET H-1
PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
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	136,784				5
HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	305,388				6
7	Physical Therapy	49,636				7
8	Occupational Therapy	12,140				8
9	Speech Pathology	2,135				9
10	Medical Social Services					10
11	Home Health Aide	67,436				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)	573,519				24

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7175

WORKSHEET H-1
PART I

	TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
	4	4A	5	6	
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		136,784	136,784	5
HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		305,388	95,646	401,034
7	Physical Therapy		49,636	15,546	65,182
8	Occupational Therapy		12,140	3,802	15,942
9	Speech Pathology		2,135	669	2,804
10	Medical Social Services				10
11	Home Health Aide		67,436	21,121	88,557
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)		573,519		573,519

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS					
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)
		1	2	3	4	5A	5
GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures						
2	Capital Related-Movable Equipment						
3	Plant Operation & Maintenance						
4	Transportation (see instructions)						
5	Administrative and General					-136,784	436,735
HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						305,388
7	Physical Therapy						49,636
8	Occupational Therapy						12,140
9	Speech Pathology						2,135
10	Medical Social Services						
11	Home Health Aide						67,436
12	Supplies (see instructions)						
13	Drugs						
14	DME						
HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services						
16	Respiratory Therapy						
17	Private Duty Nursing						
18	Clinic						
19	Health Promotion Activities						
20	Day Care Program						
21	Home Delivered Means Program						
22	Homemaker Service						
23	All Others						
23.50	Telemedicine						
24	Totals (sum of lines 1-23)					-136,784	436,735
25	Cost To Be Allocated (per Worksheet H-1, Part I)						136,784
26	Unit Cost Multiplier						0.313197

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
1	Administrative and General			569	27,784	863		1
2	Skilled Nursing Care	401,034			62,606			2
3	Physical Therapy	65,182			9,311			3
4	Occupational Therapy	15,942			2,428			4
5	Speech Pathology	2,804			370			5
6	Medical Social Services							6
7	Home Health Aide	88,557			13,466			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)	573,519		569	115,965	863		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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
1	Administrative and General	3,123		18,905	51,244	4,869		1
2	Skilled Nursing Care				463,640	44,049		2
3	Physical Therapy				74,493	7,077		3
4	Occupational Therapy				18,370	1,745		4
5	Speech Pathology				3,174	302		5
6	Medical Social Services							6
7	Home Health Aide				102,023	9,693		7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)	3,123		18,905	712,944	67,735		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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
1	Administrative and General		2,909		16,057	84,144		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)		2,909		16,057	84,144		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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL (sum of col.4A-23) 24	I&R COST & POST STEP- DOWN ADJS 25	SUBTOTAL (cols 23 +/- 24) 26	
		15	16	17	24	25	26	
1	Administrative and General			2,147	161,370		161,370	1
2	Skilled Nursing Care				507,689		507,689	2
3	Physical Therapy				81,570		81,570	3
4	Occupational Therapy				20,115		20,115	4
5	Speech Pathology				3,476		3,476	5
6	Medical Social Services							6
7	Home Health Aide				111,716		111,716	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)			2,147	885,936		885,936	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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	ALLOCATED HHA A&G (see PII) 27	TOTAL HHA COSTS 28				
1	Administrative and General						1
2	Skilled Nursing Care	113,068	620,757				2
3	Physical Therapy	18,167	99,737				3
4	Occupational Therapy	4,480	24,595				4
5	Speech Pathology	774	4,250				5
6	Medical Social Services						6
7	Home Health Aide	24,881	136,597				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)	161,370	885,936				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.	0.222713					21

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

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-2
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5.01	5.02	5.03	
1	Administrative and General		796	115,887	9			10 1
2	Skilled Nursing Care			261,132				2
3	Physical Therapy			38,836				3
4	Occupational Therapy			10,129				4
5	Speech Pathology			1,545				5
6	Medical Social Services							6
7	Home Health Aide			56,166				7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		796	483,695	9			10 20
21	Total cost to be allocated		569	115,965	863			3,123 21
22	Unit Cost Multiplier			0.239748				22
22	Unit Cost Multiplier		0.714824		95.888889		312.300000	22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-2
PART II

	HHA COST CENTER	ADMITTING INPATIENT REVENUE	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION	OTHER ADMI NISTRATIVE AND GENER ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS	
		5.04	5.05	4A.06	5.06	7	8	
1	Administrative and General		960,667		51,244			1
2	Skilled Nursing Care				463,640			2
3	Physical Therapy				74,493			3
4	Occupational Therapy				18,370			4
5	Speech Pathology				3,174			5
6	Medical Social Services							6
7	Home Health Aide				102,023			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)		960,667		712,944			20
21	Total cost to be allocated		18,905		67,735			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		0.019679		0.095007			22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-2
PART II

	HHA COST CENTER	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINISTRATION NURSING HOURS	CENTRAL SERVICES & SUPPLY CSS CSTD REQ'	PHARMACY RX CSTD REQ'S	
		9	10	11	13	14	15	
1	Administrative and General	450		9	18,342			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)	450		9	18,342			20
21	Total cost to be allocated	2,909		16,057	84,144			21
22	Unit Cost Multiplier	6.464444		1,784.111111				22
22	Unit Cost Multiplier				4.587504			22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

WORKSHEET H-2
PART II

	HHA COST CENTER	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME				
		16	17				
1	Administrative and General		3				1
2	Skilled Nursing Care						2
3	Physical Therapy						3
4	Occupational Therapy						4
5	Speech Pathology						5
6	Medical Social Services						6
7	Home Health Aide						7
8	Supplies						8
9	Drugs						9
10	DME						10
11	Home Dialysis Aide Services						11
12	Respiratory Therapy						12
13	Private Duty Nursing						13
14	Clinic						14
15	Health Promotion Activities						15
16	Day Care Program						16
17	Home Delivered Meals Program						17
18	Homemaker Service						18
19	All Others						19
19.50	Telemedicine						19.50
20	Totals (sum of lines 1-19)		3				20
21	Total cost to be allocated		2,147				21
22	Unit Cost Multiplier						22
22	Unit Cost Multiplier		715.666667				22

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7175

WORKSHEET H-3
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation								
	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	620,757		620,757	2,698	230.08	1
2	Physical Therapy	3	99,737		99,737	837	119.16	2
3	Occupational Therapy	4	24,595		24,595	276	89.11	3
4	Speech Pathology	5	4,250		4,250	75	56.67	4
5	Medical Social Services	6				4		5
6	Home Health Aide	7	136,597		136,597	800	170.75	6
7	Total (sum of lines 1-6)		885,936		885,936	4,690		7

Limitation Cost Computation					Program Visits		
Patient Services	CBSA No.	Part A	PART B				
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
	1	2	3	4			
8 Skilled Nursing Care	99914		2,315		8		
9 Physical Therapy	99914		658		9		
10 Occupational Therapy	99914		220		10		
11 Speech Pathology	99914		50		11		
12 Medical Social Services	99914		2		12		
13 Home Health Aide	99914		795		13		
14 Total (sum of lines 8-13)			4,040		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		23,382	23,382	47,686	0.490333	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	0.540788			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	0.490337	47,686	23,382	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.563041			col. 2, line 16	5

Optimizer Systems, Inc.

WinLASH System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7175

WORKSHEET H-3
PARTS I & II

Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services			
Patient Services	Part A	Part B		Part A	Part B		Total Program Cost (sum of cols 9-10)	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6	7	8	9	10	11	12	
1 Skilled Nursing Care		2,315			532,635		532,635	1
2 Physical Therapy		658			78,407		78,407	2
3 Occupational Therapy		220			19,604		19,604	3
4 Speech Pathology		50			2,834		2,834	4
5 Medical Social Services		2						5
6 Home Health Aide		795			135,746		135,746	6
7 Total (sum of lines 1-6)		4,040			769,226		769,226	7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
Other Patient Services	Part A	Part B		Part A	Part B		Total	
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6	7	8	9	10	11		
15 Cost of Medical Supplies								15
16 Cost of Drugs								16

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7175

WORKSHEET H-4
PARTS I & II

Check applicable box: [] Title V [XX] Title XVIII [] Title XIX

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

	Description	Part B		
		Part A 1	Not Subject to Deductibles & Coinsurance 2	
	Reasonable Cost of Part A & Part B Services			
1	Reasonable cost of services (see instructions)			1
2	Total charges			2
	Customary Charges			
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)			3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)			4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)			5
6	Total customary charges (see instructions)			6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)			7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)			8
9	Primary payer amounts			9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers		361,433	11
12	Total PPS Reimbursement - Full Episodes with Outliers		23,810	12
13	Total PPS Reimbursement - LUPA Episodes		6,169	13
14	Total PPS Reimbursement - PEP Episodes		4,501	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers		4,209	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)		400,122	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		400,122	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		400,122	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)		400,122	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		400,122	31
31.01	Sequestration adjustment (see instructions)	3,277	7,619	31.01
32	Interim payments (see instructions)		392,120	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	-3,277	383	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

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

WORKSHEET H-5

DESCRIPTION	Part A		Part B		
	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	1	2	3	4	
1 Total interim payments paid to provider				392,120	1
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero.					2
3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	.01				3.01
	.02				3.02
Program	.03				3.03
To	.04				3.04
Provider	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.10				3.10
	.50				3.50
	.51				3.51
Provider	.52				3.52
To	.53				3.53
Program	.54				3.54
	.55				3.55
	.56				3.56
	.57				3.57
	.58				3.58
	.59				3.59
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)				392,120	4
TO BE COMPLETED BY CONTRACTOR					
5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)					
	.01				5.01
	.02				5.02
Program	.03				5.03
To	.04				5.04
Provider	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	.10				5.10
	.50				5.50
	.51				5.51
Provider	.52				5.52
To	.53				5.53
Program	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6 Determine net settlement amount (balance due) based on the cost report (see instructions)	.01			8,002	6.01
	.02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				400,122	7
8 Name of Contractor	Contractor Number		NPR Date: Month, Day, Year		8

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

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-1343

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

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

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING RECEIVING AND STORES						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
43	Nursery						43
44	Skilled Nursing Facility						44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
54.01	RADIOLOGY-ULTRASOUND						54.01
60	Laboratory						60
62	Whole Blood & Packed Red Blood Cells						62
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76	CARDIAC REHAB						76
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic						88
88.01	RHC II						88.01
88.02	RHC III						88.02
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency						101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
194	NONREIMBURSEABLE						194
194.01	PROFESSIONAL BUILDINGS						194.01
194.02	FOUNDATION SERVICES						194.02
194.03	WELLNESS						194.03
194.04	RENTED SPACE						194.04
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202

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

COMPONENT CCN: 14-3429

WORKSHEET M-1

Check applicable box: RHC I FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
FACILITY HEALTH CARE STAFF COSTS								
1	Physician	2,140,423	2,140,423		2,140,423	-208,909	1,931,514	1
2	Physician Assistant							2
3	Nurse Practitioner	211,573	211,573		211,573		211,573	3
4	Visiting Nurse							4
5	Other Nurse							5
6	Clinical Psychologist							6
7	Clinical Social Worker							7
8	Laboratory Technician							8
9	Other Facility Health Care Staff Costs	903,848	229,495	1,133,343	-40,640	1,092,703	-182,275	910,428
10	Subtotal (sum of lines 1 through 9)	3,255,844	229,495	3,485,339	-40,640	3,444,699	-391,184	3,053,515
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		229,892	229,892		229,892	229,892	15
16	Transportation (Health Care Staff)							16
17	Depreciation-Medical Equipment				-182,969	-182,969	-182,969	17
18	Professional Liability Insurance		141,163	141,163		141,163	141,163	18
19	Other Health Care Costs							19
20	Allowable GME Costs							20
21	Subtotal (sum of lines 15 through 20)		371,055	371,055	-182,969	188,086	188,086	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,255,844	600,550	3,856,394	-223,609	3,632,785	-391,184	3,241,601
COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy							23
24	Dental							24
25	Optometry							25
26	All other nonreimbursable costs							26
27	Nonallowable GME costs							27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)							28
FACILITY OVERHEAD								
29	Facility Costs				61,119	61,119	61,119	29
30	Administrative Costs	837,934		837,934		837,934	837,934	30
31	Total Facility Overhead (sum of lines 29 and 30)	837,934		837,934	61,119	899,053	899,053	31
32	Total facility costs (sum of lines 22, 28 and 31)	4,093,778	600,550	4,694,328	-162,490	4,531,838	-391,184	4,140,654

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.

Optimizer Systems, Inc.

WinLASH System

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3429

WORKSHEET M-2

Check applicable box: RHC I FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians	5.43	25,044	4,200	22,806		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.92	2,167	2,100	1,932		3
4	Subtotal (sum of lines 1 through 3)	6.35	27,211		24,738	27,211	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)	6.35	27,211			27,211	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)					3,241,601	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)					3,241,601	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)					899,053	14
15	Parent provider overhead allocated to facility (see instructions)					1,574,265	15
16	Total overhead (sum of lines 14 and 15)					2,473,318	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					2,473,318	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,473,318	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					5,714,919	20

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3429

WORKSHEET M-3

Check applicable boxes: RHC I Title V Title XIX
 FQHC Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	5,714,919	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	44,016	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	5,670,903	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	27,211	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	27,211	6
7	Adjusted cost per visit (line 3 divided by line 6)	208.40	7

		Calculation of Limit (1)		(See instr.)	
		Prior to January 1	On or after January 1		
		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)	208.40	208.40	208.40	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		7,550		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,573,420		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)		1,573,420		16
16.01	Total program charges (see instructions)(from contractor's records)		1,107,083		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,147		16.02
16.03	Total program preventive costs (see instructions)		20,107		16.03
16.04	Total program non-preventive costs (see instructions)		1,151,816		16.04
16.05	Total program cost (see instructions)		1,171,923		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		113,543		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		195,878		19
20	Net Medicare cost excluding vaccines (see instructions)		1,171,923		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		29,083		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,201,006		22
23	Allowable bad debts (see instructions)		43,761		23
23.01	Adjusted reimbursable bad debts (see instructions)		33,258		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		43,761		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,234,264		26
26.01	Sequestration adjustment (see instructions)		24,685		26.01
27	Interim payments		981,107		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		228,472		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.

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

COMPONENT CCN: 14-3429

WORKSHEET M-5

Check applicable box: RHC I FQHC

	DESCRIPTION	Part B		
		mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider		914,615	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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01	04/16/2015	66,492
		.02		3.01
		.03		3.02
		Program		3.03
		to		3.04
		Provider		3.05
		.06		3.06
		.07		3.07
		.08		3.08
		.09		3.09
		.10		3.10
		.50		3.50
		.51		3.51
		Provider		3.52
		to		3.53
		Program		3.54
		.55		3.55
		.56		3.56
		.57		3.57
		.58		3.58
		.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		66,492
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			981,107
TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01		5.01
		.02		5.02
		Program		5.03
		to		5.04
		Provider		5.05
		.06		5.06
		.07		5.07
		.08		5.08
		.09		5.09
		.10		5.10
		.50		5.50
		.51		5.51
		Provider		5.52
		to		5.53
		Program		5.54
		.55		5.55
		.56		5.56
		.57		5.57
		.58		5.58
		.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99		5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01		253,157
		.02		6.01
7	Total Medicare program liability (see instructions)			1,234,264
8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

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

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

COMPONENT CCN: 14-3486

WORKSHEET M-1

Check applicable box: RHC II FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
FACILITY HEALTH CARE STAFF COSTS								
1 Physician	6,912		6,912		6,912	-611	6,301	1
2 Physician Assistant								2
3 Nurse Practitioner	127,366		127,366		127,366		127,366	3
4 Visiting Nurse								4
5 Other Nurse								5
6 Clinical Psychologist								6
7 Clinical Social Worker								7
8 Laboratory Techician								8
9 Other Facility Health Care Staff Costs	109,480	19,449	128,929		128,929	-22,073	106,856	9
10 Subtotal (sum of lines 1 through 9)	243,758	19,449	263,207		263,207	-22,684	240,523	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		14,837	14,837		14,837		14,837	15
16 Transportation (Health Care Staff)								16
17 Depreciation-Medical Equipment								17
18 Professional Liability Insurance								18
19 Other Health Care Costs		111,839	111,839		111,839		111,839	19
20 Allowable GME Costs								20
21 Subtotal (sum of lines 15 through 20)		126,676	126,676		126,676		126,676	21
22 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	243,758	146,125	389,883		389,883	-22,684	367,199	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 Pharmacy								23
24 Dental								24
25 Optometry								25
26 All other nonreimbursable costs								26
27 Nonallowable GME costs								27
28 Total Nonreimbursable Costs (sum of lines 23 through 27)								28
FACILITY OVERHEAD								
29 Facility Costs		13,947	13,947	7,636	21,583		21,583	29
30 Administrative Costs	31,845	3,937	35,782		35,782		35,782	30
31 Total Facility Overhead (sum of lines 29 and 30)	31,845	17,884	49,729	7,636	57,365		57,365	31
32 Total facility costs (sum of lines 22, 28 and 31)	275,603	164,009	439,612	7,636	447,248	-22,684	424,564	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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3486

WORKSHEET M-2

Check applicable box: RHC II FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1	2	3	4	5		
1	Physicians	0.02	88	4,200	84		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.80	4,420	2,100	1,680		3
4	Subtotal (sum of lines 1 through 3)	0.82	4,508		1,764	4,508	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FOHC only)						7.01
7.02	Diabetes Self Management Training (FOHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	0.82	4,508			4,508	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)		367,199	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)		367,199	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)		57,365	14
15	Parent provider overhead allocated to facility (see instructions)		114,162	15
16	Total overhead (sum of lines 14 and 15)		171,527	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		171,527	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		171,527	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		538,726	20

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

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3486

WORKSHEET M-3

Check applicable boxes: RHC II Title V Title XIX
 FQHC Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	538,726	1
2	Cost of vaccines and their administration (from Wkst. M-4, line 15)	3,713	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	535,013	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	4,508	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	4,508	6
7	Adjusted cost per visit (line 3 divided by line 6)	118.68	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)	118.68	118.68	118.68	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		520		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		61,714		11
12	Program covered visits for mental health services (from contractor records)		12		12
13	Program covered cost from mental health services (line 9 x line 12)		1,424		13
14	Limit adjustment for mental health services (see instructions)		1,424		14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		63,138		16
16.01	Total program charges (see instructions)(from contractor's records)		68,652		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,645		16.02
16.03	Total program preventive costs (see instructions)		1,513		16.03
16.04	Total program non-preventive costs (see instructions)		41,059		16.04
16.05	Total program cost (see instructions)		42,572		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		10,301		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,341		19
20	Net Medicare cost excluding vaccines (see instructions)		42,572		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,295		21
22	Total reimbursable Program cost (line 20 plus line 21)		44,867		22
23	Allowable bad debts (see instructions)		2,907		23
23.01	Adjusted reimbursable bad debts (see instructions)		2,209		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,907		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		47,076		26
26.01	Sequestration adjustment (see instructions)		942		26.01
27	Interim payments		41,530		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		4,604		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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC
PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3486

WORKSHEET M-5

Check applicable box: RHC II FQHC

		Part B		
DESCRIPTION		mm/dd/yyyy	Amount	
		1	2	
1	Total interim payments paid to provider		39,998	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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01	04/16/2015	1,532
		.02		3.02
	Program	.03		3.03
	to	.04		3.04
	Provider	.05		3.05
		.06		3.06
		.07		3.07
		.08		3.08
		.09		3.09
		.10		3.10
		.50		3.50
		.51		3.51
	Provider	.52		3.52
	to	.53		3.53
	Program	.54		3.54
		.55		3.55
		.56		3.56
		.57		3.57
		.58		3.58
		.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		1,532
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			41,530
TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01		5.01
		.02		5.02
	Program	.03		5.03
	to	.04		5.04
	Provider	.05		5.05
		.06		5.06
		.07		5.07
		.08		5.08
		.09		5.09
		.10		5.10
		.50		5.50
		.51		5.51
	Provider	.52		5.52
	to	.53		5.53
	Program	.54		5.54
		.55		5.55
		.56		5.56
		.57		5.57
		.58		5.58
		.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99		5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01		5,546
		.02		6.02
7	Total Medicare program liability (see instructions)			47,076
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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

COMPONENT CCN: 14-3488

WORKSHEET M-1

Check applicable box: RHC III FQHC

	COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
	1	2	3	4	5	6	7	
FACILITY HEALTH CARE STAFF COSTS								
1 Physician	119,200		119,200	1,029	120,229	-9,111	111,118	1
2 Physician Assistant								2
3 Nurse Practitioner	126,418		126,418		126,418		126,418	3
4 Visiting Nurse								4
5 Other Nurse								5
6 Clinical Psychologist								6
7 Clinical Social Worker								7
8 Laboratory Technician								8
9 Other Facility Health Care Staff Costs	87,073	17,988	105,061	27,901	132,962	337	133,299	9
10 Subtotal (sum of lines 1 through 9)	332,691	17,988	350,679	28,930	379,609	-8,774	370,835	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		21,922	21,922		21,922		21,922	15
16 Transportation (Health Care Staff)								16
17 Depreciation-Medical Equipment								17
18 Professional Liability Insurance								18
19 Other Health Care Costs		69,717	69,717		69,717		69,717	19
20 Allowable GME Costs								20
21 Subtotal (sum of lines 15 through 20)		91,639	91,639		91,639		91,639	21
22 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	332,691	109,627	442,318	28,930	471,248	-8,774	462,474	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23 Pharmacy								23
24 Dental								24
25 Optometry								25
26 All other nonreimbursable costs								26
27 Nonallowable GME costs								27
28 Total Nonreimbursable Costs (sum of lines 23 through 27)								28
FACILITY OVERHEAD								
29 Facility Costs		39,569	39,569		39,569		39,569	29
30 Administrative Costs	26,752	51,175	77,927		77,927	3	77,930	30
31 Total Facility Overhead (sum of lines 29 and 30)	26,752	90,744	117,496		117,496	3	117,499	31
32 Total facility costs (sum of lines 22, 28 and 31)	359,443	200,371	559,814	28,930	588,744	-8,771	579,973	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.

Optimizer Systems, Inc.

WinLASH System

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3488

WORKSHEET M-2

Check applicable box: RHC III FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1	2	3	4	5		
1	Physicians	0.39	1,685	4,200	1,638		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.80	3,598	2,100	1,680		3
4	Subtotal (sum of lines 1 through 3)	1.19	5,283		3,318	5,283	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	1.19	5,283			5,283	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)		462,474	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)		462,474	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)		117,499	14
15	Parent provider overhead allocated to facility (see instructions)		165,689	15
16	Total overhead (sum of lines 14 and 15)		283,188	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		283,188	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		283,188	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		745,662	20

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3488

WORKSHEET M-3

Check applicable boxes: RHC III Title V Title XIX
 FQHC Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	745,662	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	2,520	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	743,142	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	5,283	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	5,283	6
7	Adjusted cost per visit (line 3 divided by line 6)	140.67	7

		Calculation of Limit (1)		(See instr.)	
		Prior to January 1 1	On or after January 1 2		
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			3	8
9	Rate for program covered visits (see instructions)	140.67	140.67	140.67	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		480		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		67,522		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)		67,522		16
16.01	Total program charges (see instructions)(from contractor's records)		66,709		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,174		16.02
16.03	Total program preventive costs (see instructions)		2,200		16.03
16.04	Total program non-preventive costs (see instructions)		45,281		16.04
16.05	Total program cost (see instructions)		47,481		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		8,721		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		11,163		19
20	Net Medicare cost excluding vaccines (see instructions)		47,481		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,047		21
22	Total reimbursable Program cost (line 20 plus line 21)		48,528		22
23	Allowable bad debts (see instructions)		2,165		23
23.01	Adjusted reimbursable bad debts (see instructions)		1,645		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		2,165		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		50,173		26
26.01	Sequestration adjustment (see instructions)		1,003		26.01
27	Interim payments		48,898		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		272		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: 05/01/2014 To: 04/30/2015	Run Date: 09/16/2015 Run Time: 08:16 Version: 2015.03 (06/16/2015)
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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

COMPONENT CCN: 14-3488

WORKSHEET M-5

Check applicable box: RHC III FQHC

	DESCRIPTION	Part B		
		mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider .		45,502	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 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01	04/16/2015	3.01
		.02		3.02
	Program	.03		3.03
	to	.04		3.04
	Provider	.05		3.05
		.06		3.06
		.07		3.07
		.08		3.08
		.09		3.09
		.10		3.10
		.50		3.50
		.51		3.51
	Provider	.52		3.52
	to	.53		3.53
	Program	.54		3.54
		.55		3.55
		.56		3.56
		.57		3.57
		.58		3.58
		.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			48,898
TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)	.01		5.01
		.02		5.02
	Program	.03		5.03
	to	.04		5.04
	Provider	.05		5.05
		.06		5.06
		.07		5.07
		.08		5.08
		.09		5.09
		.10		5.10
		.50		5.50
		.51		5.51
	Provider	.52		5.52
	to	.53		5.53
	Program	.54		5.54
		.55		5.55
		.56		5.56
		.57		5.57
		.58		5.58
		.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99		5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01		1,275
		.02		6.02
7	Total Medicare program liability (see instructions)			50,173
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.