

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☒ Electronically filed cost report 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 09/28/2019 Time: 11:00	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CRAWFORD MEMORIAL HOSPITAL (14-1343) (Provider Name(s) and Number(s)) for the cost reporting period beginning 05/01/2018 and ending 04/30/2019, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) DOUG FLORKOWSKI
 Chief Financial Officer or Administrator of Provider(s)

CHIEF EXECUTIVE OFFICER
 Title

09/28/2019 11:00
 Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		231,903	30,319			1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		44,004				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY		1,353				7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			180,791			10
10.01	HEALTH CLINIC - RHC II			42,214			10.01
10.02	HEALTH CLINIC - RHC III			40,677			10.02
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		277,260	294,001			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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
	0	1	2	3	4	5	V	XVIII	XIX	
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 / 2018	To: 04 / 30 / 2019		20
21	Type of control (see instructions)	11			21

Inpatient PPS Information

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

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

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)							37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

		1	2	3	
56	Teaching Hospitals 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, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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. Enter in column 4, the direct GME FTE unweighted count.

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

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

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

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 through 67. (see instructions)	N			63
----	--	---	--	--	----

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

		1	2	
105	Does this hospital qualify as a CAH?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	Physical Occupational Speech Respiratory	109

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	N		111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-L, chapter 22, section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118
118.01	List amounts of malpractice premiums and paid losses:	Premiums Paid Losses	Self Insurance	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

Transplant Center Information

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

All Providers

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

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

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

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1		168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	05 / 01 / 2017	04 / 30 / 2018	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

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

COMPLETED BY ALL HOSPITALS

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

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

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see 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	08/23/2018	Y	08/23/2018	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R 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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

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

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

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

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

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	59,928.00		1,197	455	2,737	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						525		534	5
6	Hospital Adults & Peds. Swing Bed NF								11	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	59,928.00		1,722	455	3,282	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						67	366	13
14	Total (see instructions)		25	9,125	59,928.00		1,722	522	3,648	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44	35	12,775			1,152		6,864	19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101					2,460	333	3,073	22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					6,910		27,331	26
26.01	RHC II	88.01					535		2,929	26.01
26.02	RHC III	88.02					962		5,813	26.02
27	Total (sum of lines 14-26)		60							27
28	Observation Bed Days								339	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							33	65	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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)					672	190	1,312	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)		260.42			672	190	1,312	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility		21.13						19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency		8.30						22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		34.33						26
26.01	RHC II		4.01						26.01
26.02	RHC III		7.05						26.02
27	Total (sum of lines 14-26)		335.24						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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		457		20	477	1
2	Unduplicated Census Count (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week 40.00	Number of Employees (Full Time Equivalent)			
		Staff 1	Contract 2	Total 3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)	1.01		1.01	4
5	Other Administrative Personnel	1.05		1.05	5
6	Direct Nursing Service	3.91		3.91	6
7	Nursing Supervisor				7
8	Physical Therapy Service	0.35		0.35	8
9	Physical Therapy Supervisor	0.37		0.37	9
10	Occupational Therapy Service	0.14		0.14	10
11	Occupational Therapy Supervisor	0.01		0.01	11
12	Speech Pathology Service	0.01		0.01	12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide	1.28		1.28	16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

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

PPS ACTIVITY

		Full Episodes				Total (columns 1 through 4)	
		Without Outliers 1	With Outliers 2	LUPA Episodes 3	PEP only Episodes 4		
21	Skilled Nursing Visits	1,133	139	48	14	1,334	21
22	Skilled Nursing Visit Charges	254,187	31,248	10,800	3,096	299,331	22
23	Physical Therapy Visits	665	22	9	7	703	23
24	Physical Therapy Visit Charges	153,408	5,073	2,079	1,572	162,132	24
25	Occupational Therapy Visits	124	3	3	2	132	25
26	Occupational Therapy Visit Charges	28,608	684	693	453	30,438	26
27	Speech Pathology Visits	22	4			26	27
28	Speech Pathology Visit Charges	5,055	924			5,979	28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits	234	17	3	11	265	31
32	Home Health Aide Visit Charges	24,958	1,819	321	1,147	28,245	32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,178	185	63	34	2,460	33
34	Other Charges	25,290	1,825	696	1,861	29,672	34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)	491,506	41,573	14,589	8,129	555,797	35
36	Total Number of Episodes (standard/non-outlier)	130		22	3	155	36
37	Total Number of Ourlier Episodes		6			6	37
38	Total Non-Routine Medical Supply Charges	25,290	1,825	696	1,861	29,672	38

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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				15
16	RVB	44		44	16
17	RVA	47		47	17
18	RHC	151		151	18
19	RHB	146		146	19
20	RHA	383		383	20
21	RMC	49		49	21
22	RMB	43		43	22
23	RMA	45		45	23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1	23		23	28
29	HE2				29
30	HE1	7		7	30
31	HD2				31
32	HD1				32
33	HC2	14		14	33
34	HC1				34
35	HB2				35
36	HB1	11		11	36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1	74		74	40
41	LC2				41
42	LC1	4		4	42
43	LB2				43
44	LB1	13		13	44
45	CE2				45
46	CE1	16		16	46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1	46		46	52
53	CA2				53
54	CA1	25		25	54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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				72
73	PC2				73
74	PC1	4		4	74
75	PB2				75
76	PB1	7		7	76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL	1,152		1,152	200

SNF SERVICES

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

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each 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	858,154	71.11%		202
203	Recruitment				203
204	Retention of employees				204
205	Training	1,675	0.14%		205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)	1,206,747			207

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3429

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

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

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

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3486

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3488

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0800	1700	0800	1700	0800	1700	0800	1700	0800	1700			11

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

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

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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)	0.477551	1
---	--	----------	---

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,172,952	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	3,865,199	5
6	Medicaid charges	13,120,189	6
7	Medicaid cost (line 1 times line 6)	6,265,559	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.	227,408	8

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

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

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

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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng 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)	227,408	19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,210,979	965,970	2,176,949	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	578,304	965,970	1,544,274	21
22	Payments received from patients for amounts previously written off as charity care	72,649	57,955	130,604	22
23	Cost of charity care (line 21 minus line 22)	505,655	908,015	1,413,670	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	2,690,570	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	270,965	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	416,868	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,273,702	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,231,712	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	2,645,382	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,872,790	31

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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		2,992,359	2,992,359	338,802	3,331,161	-211,451	3,119,710	1
2	00200	Cap Rel Costs-Mvble Equip		1,360,992	1,360,992	7,055	1,368,047		1,368,047	2
3	00300	Other Cap Rel Costs		27,576	27,576	-27,576			-0-	3
4	00400	Employee Benefits Department	257,556	3,668,741	3,926,297	2,481	3,928,778	-48,321	3,880,457	4
5.01	00540	NONPATIENT TELEPHONES				32,374	32,374		32,374	5.01
5.02	00550	DATA PROCESSING	252,691	1,440,824	1,693,515		1,693,515		1,693,515	5.02
5.03	00560	PURCHASING RECEIVING AND STORES	163,475	74,017	237,492		237,492		237,492	5.03
5.04	00570	ADMITTING	541,482	78,911	620,393	-33,025	587,368		587,368	5.04
5.05	00580	CASHIERING/ACCOUNTS RECEIVABLE	599,183	573,232	1,172,415		1,172,415		1,172,415	5.05
5.06	00590	OTHER ADMINISTRATIVE AND GENERAL	1,300,604	2,638,992	3,939,596	-3,029	3,936,567	-246,323	3,690,244	5.06
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	434,738	1,267,752	1,702,490	42,814	1,745,304	-1,440	1,743,864	7
8	00800	Laundry & Linen Service	64,059	50,954	115,013		115,013		115,013	8
9	00900	Housekeeping	397,269	164,477	561,746		561,746		561,746	9
10	01000	Dietary	513,054	407,853	920,907	-507,787	413,120		413,120	10
11	01100	Cafeteria				507,787	507,787	-149,629	358,158	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	598,799	52,042	650,841		650,841		650,841	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	694,064	2,095,009	2,789,073		2,789,073	-25,169	2,763,904	15
16	01600	Medical Records & Library	447,218	234,869	682,087		682,087	-8,156	673,931	16
17	01700	Social Service	56,957	4,748	61,705		61,705		61,705	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	3,029,389	394,483	3,423,872	-216,923	3,206,949	-1,074,409	2,132,540	30
43	04300	Nursery				75,130	75,130		75,130	43
44	04400	Skilled Nursing Facility	1,036,903	265,182	1,302,085	187,860	1,489,945		1,489,945	44
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	839,599	577,786	1,417,385	1,158,349	2,575,734	-867,173	1,708,561	50
52	05200	Delivery Room & Labor Room		710	710	141,793	142,503		142,503	52
53	05300	Anesthesiology	829,395	328,954	1,158,349	-1,158,349				53
54	05400	Radiology-Diagnostic	702,501	742,865	1,445,366	-9,529	1,435,837	-100	1,435,737	54
54.01	05401	RADIOLOGY-ULTRASOUND	151,326	31,123	182,449		182,449		182,449	54.01
60	06000	Laboratory	646,970	1,026,870	1,673,840	-47,144	1,626,696		1,626,696	60
62	06200	Whole Blood & Packed Red Blood Cells		57,199	57,199	47,144	104,343		104,343	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	412,497	145,977	558,474		558,474	-25,280	533,194	65
66	06600	Physical Therapy	1,121,519	190,176	1,311,695	-8,177	1,303,518		1,303,518	66
69	06900	Electrocardiology	13,951	3,208	17,159		17,159		17,159	69
71	07100	Medical Supplies Charged to Patients		719,751	719,751	-337,370	382,381		382,381	71
72	07200	Impl. Dev. Charged to Patients				341,225	341,225	-218,000	123,225	72
73	07300	Drugs Charged to Patients				9,529	9,529		9,529	73
76	03950	CARDIAC REHAB	14,678	12,057	26,735		26,735		26,735	76
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	3,415,889	683,487	4,099,376	150,415	4,249,791	-56,246	4,193,545	88
88.01	08801	RHC II	279,226	115,237	394,463	8,241	402,704	-1,587	401,117	88.01
88.02	08802	RHC III	595,837	134,090	729,927	84,114	814,041	-4,678	809,363	88.02
90	09000	Clinic	2,077,861	1,938,514	4,016,375	24,918	4,041,293	-1,692,358	2,348,935	90
90.01	09001	PAIN MANAGEMENT CLINIC	90,981	31,559	122,540		122,540		122,540	90.01
91	09100	Emergency	812,514	1,988,168	2,800,682		2,800,682	-1,329,390	1,471,292	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
101	10100	Home Health Agency	487,742	94,625	582,367	9,828	592,195		592,195	101
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		858,100	858,100	-858,100				113
118		SUBTOTALS (sum of lines 1-117)	22,879,927	27,473,469	50,353,396	-37,150	50,316,246	-5,959,710	44,356,536	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	46,236	13,293	59,529	13,246	72,775		72,775	192
192.10	19201	PHYSICIAN HOSPITALIST								192.10
194	07950	NONREIMBURSEABLE				3,029	3,029		3,029	194
194.01	07951	PROFESSIONAL BUILDINGS		128,796	128,796	16,229	145,025		145,025	194.01
194.02	07952	FOUNDATION SERVICES	38,986	7,024	46,010		46,010		46,010	194.02

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194.03	07953	WELLNESS	73,721	20,796	94,517	4,646	99,163		99,163	194.03
194.04	07954	RENTED SPACE								194.04
194.05	07955	LITIGATION COSTS								194.05
200		TOTAL (sum of lines 118-199)	23,038,870	27,643,378	50,682,248		50,682,248	-5,959,710	44,722,538	200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	LTC ADMITTING COSTS	A	Skilled Nursing Facility	44	558	93	1
500	Total reclassifications				558	93	500
	Code Letter - A						
1	CAFETERIA COSTS	B	Cafeteria	11	281,121	226,666	1
500	Total reclassifications				281,121	226,666	500
	Code Letter - B						
1	COST OF BLOOD	C	Whole Blood & Packed Red Bloo	62		47,144	1
500	Total reclassifications					47,144	500
	Code Letter - C						
1	HHA MED SUPPLIES	D	Medical Supplies Charged to P	71		3,855	1
500	Total reclassifications					3,855	500
	Code Letter - D						
1	PBX COSTS	E	NONPATIENT TELEPHONES	5.01	27,740	4,634	1
500	Total reclassifications				27,740	4,634	500
	Code Letter - E						
1	DEP PROF BLDGS	F	PROFESSIONAL BUILDINGS	194.01		39,289	1
2			Rural Health Clinic	88		174,142	2
3			RHC II	88.01		8,241	3
4			Clinic	90		36,495	4
5			Home Health Agency	101		13,683	5
6			WELLNESS	194.03		7,127	6
500	Total reclassifications					278,977	500
	Code Letter - F						
1	SNF	G	Skilled Nursing Facility	44		187,209	1
500	Total reclassifications					187,209	500
	Code Letter - G						
1	LABOR/DEL & NB COSTS	H	Nursery	43	63,904	11,226	1
2			Delivery Room & Labor Room	52	121,198	20,595	2
500	Total reclassifications				185,102	31,821	500
	Code Letter - H						
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	I	Drugs Charged to Patients	73		9,529	1
500	Total reclassifications					9,529	500
	Code Letter - I						
1	OR COST	J	Operating Room	50	829,395	328,954	1
500	Total reclassifications				829,395	328,954	500
	Code Letter - J						
1	R/C PALESTINE OBLONG DRS	K	Physicians' Private Offices	192		13,246	1
2			RHC III	88.02		10,481	2
500	Total reclassifications					23,727	500
	Code Letter - K						
1	HEALTHWORKS COSTS	L	Employee Benefits Department	4	1,930	551	1
500	Total reclassifications				1,930	551	500
	Code Letter - L						
1	UTILITIES	M	Operation of Plant	7		42,814	1
2							2
500	Total reclassifications					42,814	500
	Code Letter - M						
1	INTEREST EXPENSE	N	Cap Rel Costs-Bldg & Fixt	1		858,100	1
500	Total reclassifications					858,100	500
	Code Letter - N						
1	OBLONG DEPRECIATION	O	RHC III	88.02		73,633	1
500	Total reclassifications					73,633	500
	Code Letter - O						
1	PROPERTY TAX PT	P	Physical Therapy	66		23,060	1
500	Total reclassifications					23,060	500
	Code Letter - P						
1	IMPLANTABLE DEVICES	Q	Impl. Dev. Charged to Patient	72		341,225	1
500	Total reclassifications					341,225	500
	Code Letter - Q						

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	RECLASS MAPPING DIFFERENCE	R	NONREIMBURSEABLE	194		3,029	1
500	Total reclassifications					3,029	500
	Code Letter - R						
	GRAND TOTAL (Increases)				1,325,846	2,485,021	

(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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	LTC ADMITTING COSTS	A	ADMITTING	5.04	558	93		1
500	Total reclassifications				558	93		500
	Code letter - A							
1	CAFETERIA COSTS	B	Dietary	10	281,121	226,666		1
500	Total reclassifications				281,121	226,666		500
	Code letter - B							
1	COST OF BLOOD	C	Laboratory	60		47,144		1
500	Total reclassifications					47,144		500
	Code letter - C							
1	HHA MED SUPPLIES	D	Home Health Agency	101		3,855		1
500	Total reclassifications					3,855		500
	Code letter - D							
1	PBX COSTS	E	ADMITTING	5.04	27,740	4,634		1
500	Total reclassifications				27,740	4,634		500
	Code letter - E							
1	DEP PROF BLDGS	F	Cap Rel Costs-Bldg & Fixt	1		278,977	9	1
2							9	2
3							9	3
4							9	4
5							9	5
6							9	6
500	Total reclassifications					278,977		500
	Code letter - F							
1	SNF	G	Cap Rel Costs-Bldg & Fixt	1		187,209	9	1
500	Total reclassifications					187,209		500
	Code letter - G							
1	LABOR/DEL & NB COSTS	H	Adults & Pediatrics	30	185,102	31,821		1
2								2
500	Total reclassifications				185,102	31,821		500
	Code letter - H							
1	RADIOLOGY CONTRAST ISOVIEW DRUGS	I	Radiology-Diagnostic	54		9,529		1
500	Total reclassifications					9,529		500
	Code letter - I							
1	OR COST	J	Anesthesiology	53	829,395	328,954		1
500	Total reclassifications				829,395	328,954		500
	Code letter - J							
1	R/C PALESTINE OBLONG DRS	K	Rural Health Clinic	88		23,727		1
2								2
500	Total reclassifications					23,727		500
	Code letter - K							
1	HEALTHWORKS COSTS	L	WELLNESS	194.03	1,930	551		1
500	Total reclassifications				1,930	551		500
	Code letter - L							
1	UTILITIES	M	Physical Therapy	66		31,237		1
2			Clinic	90		11,577		2
500	Total reclassifications					42,814		500
	Code letter - M							
1	INTEREST EXPENSE	N	Interest Expense	113		858,100	11	1
500	Total reclassifications					858,100		500
	Code letter - N							
1	OBLONG DEPRECIATION	O	Cap Rel Costs-Bldg & Fixt	1		73,633	9	1
500	Total reclassifications					73,633		500
	Code letter - O							
1	PROPERTY TAX PT	P	PROFESSIONAL BUILDINGS	194.01		23,060		1
500	Total reclassifications					23,060		500
	Code letter - P							
1	IMPLANTABLE DEVICES	Q	Medical Supplies Charged to P	71		341,225		1
500	Total reclassifications					341,225		500
	Code letter - Q							

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

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	RECLASS MAPPING DIFFERENCE	R	OTHER ADMINISTRATIVE AND GENE	5.06		3,029		1
500	Total reclassifications					3,029		500
	Code letter - R							
	GRAND TOTAL (Decreases)				1,325,846	2,485,021		

(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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

RECONCILIATION OF CAPITAL COST CENTERS**WORKSHEET A-7
PARTS I, II & III****PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Acquisitions				Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		Beginning Balances	Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	490,645	125,440		125,440		616,085		1
2	Land Improvements	1,115,487	167,000		167,000		1,282,487		2
3	Buildings and Fixtures	54,744,176					54,744,176		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	13,960,574	5,835,406		5,835,406	323,460	19,472,520		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	70,310,882	6,127,846		6,127,846	323,460	76,115,268		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	70,310,882	6,127,846		6,127,846	323,460	76,115,268		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	2,992,359						2,992,359	1
2	Cap Rel Costs-Mvble Equip	1,360,992						1,360,992	2
3	Total (sum of lines 1-2)	4,353,351						4,353,351	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 line 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	56,642,748		56,642,748	0.744171			20,521	20,521	1
2	Cap Rel Costs-Mvble Equip	19,472,520		19,472,520	0.255829			7,055	7,055	2
3	Total (sum of lines 1-2)	76,115,268		76,115,268	1.000000			27,576	27,576	3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	2,452,540	-211,451	858,100			20,521	3,119,710	1
2	Cap Rel Costs-Mvble Equip	1,360,992					7,055	1,368,047	2
3	Total (sum of lines 1-2)	3,813,532	-211,451	858,100			27,576	4,487,757	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.)

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

ADJUSTMENTS TO EXPENSES
WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)	B	-222,739	Cap Rel Costs-Bldg & Fixt	1	10	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-4,596,086				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	-149,629	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	-8,156	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33	PHYS RECRUITING	A	-71,198	OTHER ADMINISTRATIVE AND GENERAL	5.06		33
33.11	EMPLOYEE INJURY	A	-1,972	Employee Benefits Department	4		33.11
33.22	EMPLOYEE PHYSICALS	A	-431	Employee Benefits Department	4		33.22
34	ADVERTISING	A	-121,466	OTHER ADMINISTRATIVE AND GENERAL	5.06		34
35	TV ADMINISTRATION	A	-9,901	OTHER ADMINISTRATIVE AND GENERAL	5.06		35
36	TV UTILITIES & REPAIR	A	-1,440	Operation of Plant	7		36
37							37
38	EMPLOYEE DISCOUNTS	A	-36,510	Employee Benefits Department	4		38
39							39
40	EMPLOYEE SALES - PHARMACY	B	-25,169	Pharmacy	15		40
41							41
42	CONSULTING CLINIC	B	-84,888	Clinic	90		42
42.11	OTHER INCOME ROBINSON RHC	B	-1,843	Rural Health Clinic	88		42.11
43							43
44	OTHER INCOME PALESTINE	B	-1,587	RHC II	88.01		44
45							45
46	HOSPITALIST OTHER EXPENSES	A	-102,840	Adults & Pediatrics	30		46
47	CRNA BENEFITS	A	-62,695	Operating Room	50		47
48	PHYSICIAN BENEFITS	A	-179,682	Clinic	90		48
48.15	PHYSICIAN BENEFITS	A	-9,408	Employee Benefits Department	4		48.15
48.25	OTHER A&G	A	-41,580	OTHER ADMINISTRATIVE AND GENERAL	5.06		48.25
49							49
49.02	MISC INCOME	B	-2,882	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.02
49.03	AHA & IHA DUES	A	-13,099	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.03
49.04	OB LOCUM TENUMS	A	-21,500	Adults & Pediatrics	30		49.04
49.05	NONPATIENT CPR	B	-170	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.05
49.07	DONATIONS, PROJECTS	B	-40,535	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.07
49.13	ADMIN CLAIMS FEES	A	54,508	OTHER ADMINISTRATIVE AND GENERAL	5.06		49.13
49.14	AMORT BOND ISSUE COST	A	11,288	Cap Rel Costs-Bldg & Fixt	1	10	49.14
49.20	MRI RENT	B	-100	Radiology-Diagnostic	54		49.20
49.30	IMPLANTABLE DEVICES	A	-218,000	Impl. Dev. Charged to Patients	72		49.30
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-5,959,710				50

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5

- (1) 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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

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

WORKSHEET A-8-1

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1	90.01	PAIN MANAGEMENT CLINIC	SALARIES	106,866	106,866			1
2	90.01	PAIN MANAGEMENT CLINIC	OTHER EXPENSES	67,848	67,848			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			174,714	174,714			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		
	1	2	3	Name	Percentage of Ownership	Type of Business
6	B			CRAWFORD MEM HOSP PAIN MGMT LL	51.00	PAIN MANAGEMENT SERVICES
7						
8						
9						
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:

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	25,280	25,280						1
2	91	Emergency AGGREGATE	1,790,282	1,329,390	460,891					2
3	30	Adults & Pediatrics HOSPITALIST	950,069	950,069						3
4	90	Clinic AGGREGATE	1,427,788	1,427,788						4
5	88	Rural Health Clinic AGGREGATE	54,403	54,403						5
6	88.02	RHC III AGGREGATE	4,678	4,678						6
7										7
8	50	Operating Room AGGREGATE	804,478	804,478						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	5,056,978	4,596,086	460,891					200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

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							25,280	1
2	91	Emergency AGGREGATE							1,329,390	2
3	30	Adults & Pediatrics HOSPITALIST							950,069	3
4	90	Clinic AGGREGATE							1,427,788	4
5	88	Rural Health Clinic AGGREGATE							54,403	5
6	88.02	RHC III AGGREGATE							4,678	6
7										7
8	50	Operating Room AGGREGATE							804,478	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							4,596,086	200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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)						35	1
2	Line 1 multiplied by 15 hours per week						525	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						175	3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)							4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)							5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)							6
7	Standard travel expense rate							7
8	Optional travel expense rate							8
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1	2	3	4	5		
9	Total hours worked		1,185.00					9
10	AHSEA (see instructions)		78.66					10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	39.33	39.33					11
12	Number of travel hours (provider site) (see instructions)							12
12.01	Number of travel hours (offsite) (see instructions)							12.01
13	Number of miles driven (provider site) (see instructions)							13
13.01	Number of miles driven (offsite) (see instructions)							13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)			14
15	Therapists (column 2, line 9 times column 2, line 10)	93,212		15
16	Assistants (column 3, line 9 times column 3, line 10)			16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	93,212		17
18	Aides (column 4, line 9 times column 4, line 10)			18
19	Trainees (column 5, line 9 times column 5, line 10)			19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	93,212		20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.			
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)			21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)			22
23	Total salary equivalency (see instructions)	93,212		23

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

Standard Travel Allowance				
24	Therapists (line 3 times column 2, line 11)	6,883		24
25	Assistants (line 4 times column 3, line 11)			25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	6,883		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)			27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,883		28
Optional Travel Allowance and Optional Travel Expense				
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)			29
30	Assistants (column 3, line 10 times column 3, line 12)			30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)			31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)			32
33	Standard travel allowance and standard travel expense (line 28)	6,883		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)			34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)			35

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

Standard Travel Expense				
36	Therapists (line 5 times column 2, line 11)			36
37	Assistants (line 6 times column 3, line 11)			37
38	Subtotal (sum of lines 36 and 37)			38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)			39
Optional Travel Allowance and Optional Travel Expense				
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)			40
41	Assistants (column 3, line 9 times column 3, line 10)			41
42	Subtotal (sum of lines 40 and 41)			42
43	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)			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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	Overtime hours worked during reporting period (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	17.00				17.00	47
48	Overtime rate (see instructions)	117.99					48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	2,006					49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)	100.00				100.00	50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2,080.00				2,080.00	51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)	78.66					52
53	Overtime cost limitation (line 51 times line 52)	163,613					53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)	2,006					54
55	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1,337					55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	669				669	56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	93,212	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	6,883	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)	669	60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	100,764	63
64	Total cost of outside supplier services (from provider records)	85,546	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	3,119,710	3,119,710					1
2	Cap Rel Costs-Mvble Equip	1,368,047		1,368,047				2
4	Employee Benefits Department	3,880,457	21,555	1,829	3,903,841			4
5.01	NONPATIENT TELEPHONES	32,374			5,283	37,657		5.01
5.02	DATA PROCESSING	1,693,515	19,240	399,354	48,124	1,915	2,162,148	5.02
5.03	PURCHASING RECEIVING AND STORES	237,492	55,032	1,103	31,133	479		5.03
5.04	ADMITTING	587,368	18,195	2,308	97,734	957		5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,172,415	30,092	3,525	114,112	798	1,362,802	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	3,690,244	225,354	7,984	247,695	2,792	799,346	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	1,743,864	204,720	69,719	82,794	638		7
8	Laundry & Linen Service	115,013	63,196	3,262	12,200	80		8
9	Housekeeping	561,746	20,609	1,312	75,658	80		9
10	Dietary	413,120	91,496	17,357	44,171	558		10
11	Cafeteria	358,158	48,934		53,538			11
12	Maintenance of Personnel							12
13	Nursing Administration	650,841	16,875		114,039	479		13
14	Central Services & Supply							14
15	Pharmacy	2,763,904	31,560	102,951	132,182	798		15
16	Medical Records & Library	673,931	77,358	11,837	85,171	1,277		16
17	Social Service	61,705	2,091	268	10,847	160		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,132,540	331,983	80,146	541,683	4,388		30
43	Nursery	75,130	15,805		12,170	160		43
44	Skilled Nursing Facility	1,489,945		24,003	197,580	2,234		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,708,561	516,442	223,419	164,644	1,835		50
52	Delivery Room & Labor Room	142,503	32,606		23,082			52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,435,737	84,551	207,845	133,789	1,356		54
54.01	RADIOLOGY-ULTRASOUND	182,449	12,072	2,408	28,819			54.01
60	Laboratory	1,626,696	42,512	22,873	123,213	638		60
62	Whole Blood & Packed Red Blood Cells	104,343	2,738					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	533,194	38,131	26,007	78,558	479		65
66	Physical Therapy	1,303,518	249,472	9,351	213,589	558		66
69	Electrocardiology	17,159	6,770		2,657	160		69
71	Medical Supplies Charged to Patients	382,381	37,708	116				71
72	Impl. Dev. Charged to Patients	123,225	13,167					72
73	Drugs Charged to Patients	9,529						73
76	CARDIAC REHAB	26,735	57,197	11,095	2,795	160		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	4,193,545		17,211	642,748	5,424		88
88.01	RHC II	401,117		680	53,177	558		88.01
88.02	RHC III	809,363		9,757	112,780	2,074		88.02
90	Clinic	2,348,935	339,325	30,476	120,408	4,149		90
90.01	PAIN MANAGEMENT CLINIC	122,540	18,767	4,039	17,327	239		90.01
91	Emergency	1,471,292	238,944	46,963	154,740	957		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	592,195		1,843	92,889	718		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	44,356,536	2,964,497	1,341,041	3,871,329	37,098	2,162,148	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		17,423					190
192	Physicians' Private Offices	72,775		4,541	13,601			192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE	3,029						194
194.01	PROFESSIONAL BUILDINGS	145,025	49,680	16,807		399		194.01
194.02	FOUNDATION SERVICES	46,010	1,244	103	5,310	80		194.02
194.03	WELLNESS	99,163	86,866	5,555	13,601	80		194.03
194.04	RENTED SPACE							194.04

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	DATA PROCE SSING	
		0	1	2	4	5.01	5.02	
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	44,722,538	3,119,710	1,368,047	3,903,841	37,657	2,162,148	202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES	325,239						5.03
5.04	ADMITTING	968	707,530					5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	687		2,684,431				5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	4,761			4,978,176	4,978,176		5.06
6	Maintenance & Repairs							6
7	Operation of Plant	3,187			2,104,922	263,652	2,368,574	7
8	Laundry & Linen Service	2,063			195,814	24,527	54,100	8
9	Housekeeping	5,859			665,264	83,328	17,643	9
10	Dietary	20,651			587,353	73,569	78,327	10
11	Cafeteria				460,630	57,696	41,891	11
12	Maintenance of Personnel							12
13	Nursing Administration	102			782,336	97,991	14,447	13
14	Central Services & Supply							14
15	Pharmacy	120,303			3,151,698	394,766	27,018	15
16	Medical Records & Library	806			850,380	106,514	66,224	16
17	Social Service	57			75,128	9,410	1,790	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,497	220,767	149,696	3,468,700	434,472	284,201	30
43	Nursery		25,945	17,592	146,802	18,388	13,530	43
44	Skilled Nursing Facility	7,466			1,721,228	215,592	231,955	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	32,593	111,358	405,324	3,164,176	396,329	442,110	50
52	Delivery Room & Labor Room		12,246	10,760	221,197	27,706	27,913	52
53	Anesthesiology							53
54	Radiology-Diagnostic	6,476	49,836	572,094	2,491,684	312,096	72,382	54
54.01	RADIOLOGY-ULTRASOUND	27	12,552	96,525	334,852	41,942	10,334	54.01
60	Laboratory	26,881	75,151	538,373	2,456,337	307,668	36,393	60
62	Whole Blood & Packed Red Blood Cells	3,217	9,446	12,889	132,633	16,613	2,344	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,335	22,522	44,287	746,513	93,504	32,643	65
66	Physical Therapy	1,172	42,326	138,975	1,958,961	245,370	213,566	66
69	Electrocardiology		3,148	24,451	54,345	6,807	5,796	69
71	Medical Supplies Charged to Patients	33,075	22,485	36,385	512,150	64,149	32,281	71
72	Impl. Dev. Charged to Patients	13,510	6,715	10,819	167,436	20,972	11,272	72
73	Drugs Charged to Patients		78,250	226,702	314,481	39,390		73
76	CARDIAC REHAB	76	40	6,523	104,621	13,104	48,965	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	14,099			4,873,027	610,370		88
88.01	RHC II	1,523			457,055	57,248		88.01
88.02	RHC III	2,192			936,166	117,259		88.02
90	Clinic	6,300	86	71,865	2,921,544	365,938	290,486	90
90.01	PAIN MANAGEMENT CLINIC	290		1,101	164,303	20,580	16,066	90.01
91	Emergency	4,271	14,657	299,821	2,231,645	279,525	204,553	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	911		20,249	708,805	88,781		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	324,355	707,530	2,684,431	44,140,362	4,905,256	2,278,230	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				17,423	2,182	14,915	190
192	Physicians' Private Offices				90,917	11,388		192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE				3,029	379		194
194.01	PROFESSIONAL BUILDINGS	108			212,019	26,556		194.01
194.02	FOUNDATION SERVICES	119			52,866	6,622	1,065	194.02
194.03	WELLNESS	657			205,922	25,793	74,364	194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.03	5.04	5.05	4A	5.06	7	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	325,239	707,530	2,684,431	44,722,538	4,978,176	2,368,574	202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	274,441						8
9	Housekeeping		766,235					9
10	Dietary	5,829	21,917	766,995				10
11	Cafeteria		11,722		571,939			11
12	Maintenance of Personnel							12
13	Nursing Administration		4,042		18,116	916,932		13
14	Central Services & Supply							14
15	Pharmacy		7,560		18,116	60,720	3,659,878	15
16	Medical Records & Library		18,531		25,880			16
17	Social Service		501		2,588	7,607		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	90,081	79,525	246,285	93,166	293,027		30
43	Nursery	599	3,786		2,588	6,582		43
44	Skilled Nursing Facility	60,778	64,906	471,342	54,347	173,824		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	35,411	123,713	24,182	38,819	125,391		50
52	Delivery Room & Labor Room	1,304	7,811		5,176	12,488		52
53	Anesthesiology							53
54	Radiology-Diagnostic	16,175	20,254		33,643			54
54.01	RADIOLOGY-ULTRASOUND		2,892					54.01
60	Laboratory	376	10,184		28,468			60
62	Whole Blood & Packed Red Blood Cells		656					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,293	9,134		15,528	48,738		65
66	Physical Therapy		59,760		33,643			66
69	Electrocardiology		1,622					69
71	Medical Supplies Charged to Patients		9,033					71
72	Impl. Dev. Charged to Patients		3,154					72
73	Drugs Charged to Patients						3,659,878	73
76	CARDIAC REHAB		13,701					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,563	108,949		87,991			88
88.01	RHC II	153						88.01
88.02	RHC III	179						88.02
90	Clinic	2,157	81,284		36,231			90
90.01	PAIN MANAGEMENT CLINIC		4,496		2,588			90.01
91	Emergency	54,884	57,238	25,186	38,819	120,233		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		2,683		20,704	68,322		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	272,782	729,054	766,995	556,411	916,932	3,659,878	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,174					190
192	Physicians' Private Offices				2,588			192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		11,901					194.01
194.02	FOUNDATION SERVICES		298					194.02
194.03	WELLNESS	1,659	20,808		12,940			194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	
		8	9	10	11	13	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	274,441	766,235	766,995	571,939	916,932	3,659,878	202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		16	17	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	1,067,529						16
17	Social Service		97,024					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	61,643	65,007	5,116,107		5,116,107		30
43	Nursery	7,244		199,519		199,519		43
44	Skilled Nursing Facility		29,107	3,023,079		3,023,079		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	166,908		4,517,039		4,517,039		50
52	Delivery Room & Labor Room	4,431		308,026		308,026		52
53	Anesthesiology							53
54	Radiology-Diagnostic	235,621		3,181,855		3,181,855		54
54.01	RADIOLOGY-ULTRASOUND	39,748		429,768		429,768		54.01
60	Laboratory	221,697		3,061,123		3,061,123		60
62	Whole Blood & Packed Red Blood Cells	5,308		157,554		157,554		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,237		965,590		965,590		65
66	Physical Therapy	57,228		2,568,528		2,568,528		66
69	Electrocardiology	10,069		78,639		78,639		69
71	Medical Supplies Charged to Patients	14,983		632,596		632,596		71
72	Impl. Dev. Charged to Patients	4,455		207,289		207,289		72
73	Drugs Charged to Patients	93,354		4,107,103		4,107,103		73
76	CARDIAC REHAB	2,686		183,077		183,077		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			5,683,900		5,683,900		88
88.01	RHC II			514,456		514,456		88.01
88.02	RHC III			1,053,604		1,053,604		88.02
90	Clinic			3,697,640		3,697,640		90
90.01	PAIN MANAGEMENT CLINIC	454		208,487		208,487		90.01
91	Emergency	123,463	1,940	3,137,486		3,137,486		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		970	890,265		890,265		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	1,067,529	97,024	43,922,730		43,922,730		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			38,694		38,694		190
192	Physicians' Private Offices			104,893		104,893		192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE			3,408		3,408		194
194.01	PROFESSIONAL BUILDINGS			250,476		250,476		194.01
194.02	FOUNDATION SERVICES			60,851		60,851		194.02
194.03	WELLNESS			341,486		341,486		194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

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		
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,067,529	97,024	44,722,538		44,722,538		202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		21,555	1,829	23,384	23,384		4
5.01	NONPATIENT TELEPHONES					32	32	5.01
5.02	DATA PROCESSING		19,240	399,354	418,594	288	2	5.02
5.03	PURCHASING RECEIVING AND STORES		55,032	1,103	56,135	187		5.03
5.04	ADMITTING		18,195	2,308	20,503	586	1	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		30,092	3,525	33,617	684	1	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL		225,354	7,984	233,338	1,484	2	5.06
6	Maintenance & Repairs							6
7	Operation of Plant		204,720	69,719	274,439	496	1	7
8	Laundry & Linen Service		63,196	3,262	66,458	73		8
9	Housekeeping		20,609	1,312	21,921	453		9
10	Dietary		91,496	17,357	108,853	265		10
11	Cafeteria		48,934		48,934	321		11
12	Maintenance of Personnel							12
13	Nursing Administration		16,875		16,875	683		13
14	Central Services & Supply							14
15	Pharmacy		31,560	102,951	134,511	792	1	15
16	Medical Records & Library		77,358	11,837	89,195	510	1	16
17	Social Service		2,091	268	2,359	65		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,497	331,983	80,146	427,626	3,245	4	30
43	Nursery		15,805		15,805	73		43
44	Skilled Nursing Facility	10,516		24,003	34,519	1,184	2	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	50,155	516,442	223,419	790,016	986	2	50
52	Delivery Room & Labor Room		32,606		32,606	138		52
53	Anesthesiology							53
54	Radiology-Diagnostic		84,551	207,845	292,396	802	1	54
54.01	RADIOLOGY-ULTRASOUND		12,072	2,408	14,480	173		54.01
60	Laboratory		42,512	22,873	65,385	738	1	60
62	Whole Blood & Packed Red Blood Cells		2,738		2,738			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		38,131	26,007	64,138	471		65
66	Physical Therapy		249,472	9,351	258,823	1,280		66
69	Electrocardiology		6,770		6,770	16		69
71	Medical Supplies Charged to Patients		37,708	116	37,824			71
72	Impl. Dev. Charged to Patients		13,167		13,167			72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB		57,197	11,095	68,292	17		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			17,211	17,211	3,844	5	88
88.01	RHC II			680	680	319		88.01
88.02	RHC III	12,600		9,757	22,357	676	2	88.02
90	Clinic		339,325	30,476	369,801	721	4	90
90.01	PAIN MANAGEMENT CLINIC		18,767	4,039	22,806	104		90.01
91	Emergency		238,944	46,963	285,907	927	1	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency			1,843	1,843	557	1	101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	88,768	2,964,497	1,341,041	4,394,306	23,190	32	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		17,423		17,423			190
192	Physicians' Private Offices	1,500		4,541	6,041	81		192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		49,680	16,807	66,487			194.01
194.02	FOUNDATION SERVICES		1,244	103	1,347	32		194.02
194.03	WELLNESS		86,866	5,555	92,421	81		194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NONPATIENT TELEPHONE S	
		0	1	2	2A	4	5.01	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	90,268	3,119,710	1,368,047	4,578,025	23,384	32	202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	DATA PROCE SSING	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	OTHER ADMI NISTRATIVE AND GENER	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
	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	418,884						5.02
5.03	PURCHASING RECEIVING AND STORES		56,322					5.03
5.04	ADMITTING		168	21,258				5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	264,023	119		298,444			5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	154,861	824			390,509		5.06
6	Maintenance & Repairs							6
7	Operation of Plant		552			20,683	296,171	7
8	Laundry & Linen Service		357			1,924	6,765	8
9	Housekeeping		1,015			6,537	2,206	9
10	Dietary		3,576			5,771	9,794	10
11	Cafeteria					4,526	5,238	11
12	Maintenance of Personnel							12
13	Nursing Administration		18			7,687	1,806	13
14	Central Services & Supply							14
15	Pharmacy		20,830			30,969	3,378	15
16	Medical Records & Library		140			8,356	8,281	16
17	Social Service		10			738	224	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		1,298	6,629	16,642	34,083	35,537	30
43	Nursery			780	1,956	1,442	1,692	43
44	Skilled Nursing Facility		1,293			16,913	29,004	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		5,644	3,346	45,060	31,091	55,282	50
52	Delivery Room & Labor Room			368	1,196	2,173	3,490	52
53	Anesthesiology							53
54	Radiology-Diagnostic		1,121	1,498	63,617	24,483	9,051	54
54.01	RADIOLOGY-ULTRASOUND		5	377	10,731	3,290	1,292	54.01
60	Laboratory		4,655	2,258	59,850	24,136	4,551	60
62	Whole Blood & Packed Red Blood Cells		557	284	1,433	1,303	293	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		578	677	4,923	7,335	4,082	65
66	Physical Therapy		203	1,272	15,450	19,249	26,705	66
69	Electrocardiology			95	2,718	534	725	69
71	Medical Supplies Charged to Patients		5,728	676	4,045	5,032	4,036	71
72	Impl. Dev. Charged to Patients		2,339	202	1,203	1,645	1,409	72
73	Drugs Charged to Patients			2,352	25,202	3,090		73
76	CARDIAC REHAB		13	1	725	1,028	6,123	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		2,442			47,868		88
88.01	RHC II		264			4,491		88.01
88.02	RHC III		380			9,199		88.02
90	Clinic		1,091	3	7,989	28,707	36,323	90
90.01	PAIN MANAGEMENT CLINIC		50		122	1,614	2,009	90.01
91	Emergency		740	440	33,331	21,928	25,578	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		158		2,251	6,965		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	418,884	56,168	21,258	298,444	384,790	284,874	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					171	1,865	190
192	Physicians' Private Offices					893		192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE					30		194
194.01	PROFESSIONAL BUILDINGS		19			2,083		194.01
194.02	FOUNDATION SERVICES		21			519	133	194.02
194.03	WELLNESS		114			2,023	9,299	194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DATA PROCESsing	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENER	OPERATION OF PLANT	
		5.02	5.03	5.04	5.05	5.06	7	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	418,884	56,322	21,258	298,444	390,509	296,171	202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	
		8	9	10	11	13	15	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	75,577						8
9	Housekeeping		32,132					9
10	Dietary	1,605	919	130,783				10
11	Cafeteria		492		59,511			11
12	Maintenance of Personnel							12
13	Nursing Administration		170		1,885	29,124		13
14	Central Services & Supply							14
15	Pharmacy		317		1,885	1,929	194,612	15
16	Medical Records & Library		777		2,693			16
17	Social Service		21		269	242		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	24,809	3,335	41,995	9,694	9,306		30
43	Nursery	165	159		269	209		43
44	Skilled Nursing Facility	16,737	2,722	80,371	5,655	5,521		44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,752	5,184	4,123	4,039	3,983		50
52	Delivery Room & Labor Room	359	328		539	397		52
53	Anesthesiology							53
54	Radiology-Diagnostic	4,454	849		3,501			54
54.01	RADIOLOGY-ULTRASOUND		121					54.01
60	Laboratory	103	427		2,962			60
62	Whole Blood & Packed Red Blood Cells		28					62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	356	383		1,616	1,548		65
66	Physical Therapy		2,506		3,501			66
69	Electrocardiology		68					69
71	Medical Supplies Charged to Patients		379					71
72	Impl. Dev. Charged to Patients		132					72
73	Drugs Charged to Patients						194,612	73
76	CARDIAC REHAB		575					76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	981	4,569		9,156			88
88.01	RHC II	42						88.01
88.02	RHC III	49						88.02
90	Clinic	594	3,409		3,770			90
90.01	PAIN MANAGEMENT CLINIC		189		269			90.01
91	Emergency	15,114	2,400	4,294	4,039	3,819		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		113		2,154	2,170		101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	75,120	30,572	130,783	57,896	29,124	194,612	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		175					190
192	Physicians' Private Offices				269			192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS		499					194.01
194.02	FOUNDATION SERVICES		13					194.02
194.03	WELLNESS	457	873		1,346			194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PHARMACY	
		8	9	10	11	13	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	75,577	32,132	130,783	59,511	29,124	194,612	202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		16	17	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	NONPATIENT TELEPHONES						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING RECEIVING AND STORES						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE						5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL						5.06
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library	109,953					16
17	Social Service		3,928				17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	6,349	2,632	623,184		623,184	30
43	Nursery	746		23,296		23,296	43
44	Skilled Nursing Facility		1,178	195,099		195,099	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	17,192		975,700		975,700	50
52	Delivery Room & Labor Room	456		42,050		42,050	52
53	Anesthesiology						53
54	Radiology-Diagnostic	24,266		426,039		426,039	54
54.01	RADIOLOGY-ULTRASOUND	4,094		34,563		34,563	54.01
60	Laboratory	22,835		187,901		187,901	60
62	Whole Blood & Packed Red Blood Cells	547		7,183		7,183	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,878		87,985		87,985	65
66	Physical Therapy	5,895		334,884		334,884	66
69	Electrocardiology	1,037		11,963		11,963	69
71	Medical Supplies Charged to Patients	1,543		59,263		59,263	71
72	Impl. Dev. Charged to Patients	459		20,556		20,556	72
73	Drugs Charged to Patients	9,615		234,871		234,871	73
76	CARDIAC REHAB	277		77,051		77,051	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic			86,076		86,076	88
88.01	RHC II			5,796		5,796	88.01
88.02	RHC III			32,663		32,663	88.02
90	Clinic			452,412		452,412	90
90.01	PAIN MANAGEMENT CLINIC	47		27,210		27,210	90.01
91	Emergency	12,717	79	411,314		411,314	91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency		39	16,251		16,251	101
	SPECIAL PURPOSE COST CENTERS						
113	Interest Expense						113
118	SUBTOTALS (sum of lines 1-117)	109,953	3,928	4,373,310		4,373,310	118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen			19,634		19,634	190
192	Physicians' Private Offices			7,284		7,284	192
192.10	PHYSICIAN HOSPITALIST						192.10
194	NONREIMBURSEABLE			30		30	194
194.01	PROFESSIONAL BUILDINGS			69,088		69,088	194.01
194.02	FOUNDATION SERVICES			2,065		2,065	194.02
194.03	WELLNESS			106,614		106,614	194.03
194.04	RENTED SPACE						194.04
194.05	LITIGATION COSTS						194.05
200	Cross Foot Adjustments						200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

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		
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	109,953	3,928	4,578,025		4,578,025		202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	125,340						1
2	Cap Rel Costs-Mvble Equip		1,360,952					2
4	Employee Benefits Department	866	1,820	20,498,436				4
5.01	NONPATIENT TELEPHONES			27,740	472			5.01
5.02	DATA PROCESSING	773	397,285	252,691	24	10,000		5.02
5.03	PURCHASING RECEIVING AND STORES	2,211	1,097	163,475	6		5,025,111	5.03
5.04	ADMITTING	731	2,296	513,184	12		14,960	5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE	1,209	3,507	599,183	10	6,303	10,622	5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL	9,054	7,943	1,300,604	35	3,697	73,555	5.06
6	Maintenance & Repairs							6
7	Operation of Plant	8,225	69,357	434,738	8		49,239	7
8	Laundry & Linen Service	2,539	3,245	64,059	1		31,881	8
9	Housekeeping	828	1,305	397,269	1		90,529	9
10	Dietary	3,676	17,267	231,933	7		319,075	10
11	Cafeteria	1,966		281,121				11
12	Maintenance of Personnel							12
13	Nursing Administration	678		598,799	6		1,578	13
14	Central Services & Supply							14
15	Pharmacy	1,268	102,417	694,064	10		1,858,728	15
16	Medical Records & Library	3,108	11,776	447,218	16		12,458	16
17	Social Service	84	267	56,957	2		877	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,338	79,730	2,844,287	55		115,834	30
43	Nursery	635		63,904	2			43
44	Skilled Nursing Facility		23,879	1,037,461	28		115,350	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,749	222,260	864,516	23		503,580	50
52	Delivery Room & Labor Room	1,310		121,198				52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397	206,767	702,501	17		100,055	54
54.01	RADIOLOGY-ULTRASOUND	485	2,396	151,326			413	54.01
60	Laboratory	1,708	22,754	646,970	8		415,322	60
62	Whole Blood & Packed Red Blood Cells	110					49,709	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,532	25,872	412,497	6		51,533	65
66	Physical Therapy	10,023	9,303	1,121,519	7		18,102	66
69	Electrocardiology	272		13,951	2			69
71	Medical Supplies Charged to Patients	1,515	115				511,023	71
72	Impl. Dev. Charged to Patients	529					208,728	72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB	2,298	11,037	14,678	2		1,175	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		17,122	3,374,989	68		217,836	88
88.01	RHC II		676	279,226	7		23,526	88.01
88.02	RHC III		9,706	592,187	26		33,873	88.02
90	Clinic	13,633	30,318	632,242	52		97,343	90
90.01	PAIN MANAGEMENT CLINIC	754	4,018	90,981	3		4,477	90.01
91	Emergency	9,600	46,719	812,514	12		65,994	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		1,833	487,742	9		14,076	101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	119,104	1,334,087	20,327,724	465	10,000	5,011,451	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices		4,517	71,415				192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	1,996	16,720		5		1,673	194.01
194.02	FOUNDATION SERVICES	50	102	27,882	1		1,834	194.02
194.03	WELLNESS	3,490	5,526	71,415	1		10,153	194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross foot adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE NEW	EMPLOYEE BENEFITS DEPARTMENT GROSS SAL	NONPATIENT TELEPHONE S #OF PHONES	DATA PROCE SSING MACHINE TIME	PURCHASING RECEIVING AND STORE COST REQ'S	
		1	2	4	5.01	5.02	5.03	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,119,710	1,368,047	3,903,841	37,657	2,162,148	325,239	202
203	Unit Cost Multiplier (Wkst. B, Part I)	24.889979	1.005213	0.190446	79.781780	216.214800	0.064723	203
204	Cost to be allocated (Per Wkst. B, Part II)			23,384	32	418,884	56,322	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001141	0.067797	41.888400	0.011208	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	14,745,186						5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE		82,507,248					5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL			-4,978,176	39,744,362			5.06
6	Maintenance & Repairs							6
7	Operation of Plant				2,104,922	111,161		7
8	Laundry & Linen Service				195,814	2,539	182,679	8
9	Housekeeping				665,264	828		9
10	Dietary				587,353	3,676	3,880	10
11	Cafeteria				460,630	1,966		11
12	Maintenance of Personnel							12
13	Nursing Administration				782,336	678		13
14	Central Services & Supply							14
15	Pharmacy				3,151,698	1,268		15
16	Medical Records & Library				850,380	3,108		16
17	Social Service				75,128	84		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	4,600,937	4,600,937		3,468,700	13,338	59,961	30
43	Nursery	540,692	540,692		146,802	635	399	43
44	Skilled Nursing Facility				1,721,228	10,886	40,456	44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,320,734	12,457,703		3,164,176	20,749	23,571	50
52	Delivery Room & Labor Room	255,220	330,715		221,197	1,310	868	52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,038,592	17,584,177		2,491,684	3,397	10,767	54
54.01	RADIOLOGY-ULTRASOUND	261,582	2,966,726		334,852	485		54.01
60	Laboratory	1,566,165	16,546,991		2,456,337	1,708	250	60
62	Whole Blood & Packed Red Blood Cells	196,858	396,149		132,633	110		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	469,358	1,361,181		746,513	1,532	861	65
66	Physical Therapy	882,088	4,271,418		1,958,961	10,023		66
69	Electrocardiology	65,604	751,497		54,345	272		69
71	Medical Supplies Charged to Patients	468,595	1,118,287		512,150	1,515		71
72	Impl. Dev. Charged to Patients	139,937	332,515		167,436	529		72
73	Drugs Charged to Patients	1,630,760	6,967,723		314,481			73
76	CARDIAC REHAB	825	200,485		104,621	2,298		76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				4,873,027		2,372	88
88.01	RHC II				457,055		102	88.01
88.02	RHC III				936,166		119	88.02
90	Clinic	1,793	2,208,780		2,921,544	13,633	1,436	90
90.01	PAIN MANAGEMENT CLINIC		33,854		164,303	754		90.01
91	Emergency	305,446	9,215,067		2,231,645	9,600	36,533	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		622,351		708,805			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	14,745,186	82,507,248	-4,978,176	39,162,186	106,921	181,575	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				17,423	700		190
192	Physicians' Private Offices				90,917			192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE				3,029			194
194.01	PROFESSIONAL BUILDINGS				212,019			194.01
194.02	FOUNDATION SERVICES				52,866	50		194.02
194.03	WELLNESS				205,922	3,490	1,104	194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross foot adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	707,530	2,684,431		4,978,176	2,368,574	274,441	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.047984	0.032536		0.125255	21.307599	1.502313	203
204	Cost to be allocated (Per Wkst. B, Part II)	21,258	298,444		390,509	296,171	75,577	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.001442	0.003617		0.009826	2.664343	0.413715	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	128,513						9
10	Dietary	3,676	42,818					10
11	Cafeteria	1,966		221				11
12	Maintenance of Personnel							12
13	Nursing Administration	678		7	231,802			13
14	Central Services & Supply							14
15	Pharmacy	1,268		7	15,350	629,031		15
16	Medical Records & Library	3,108		10			79,676,117	16
17	Social Service	84		1	1,923			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,338	13,749	36	74,078		4,600,937	30
43	Nursery	635		1	1,664		540,692	43
44	Skilled Nursing Facility	10,886	26,313	21	43,943			44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,749	1,350	15	31,699		12,457,703	50
52	Delivery Room & Labor Room	1,310		2	3,157		330,715	52
53	Anesthesiology							53
54	Radiology-Diagnostic	3,397		13			17,584,177	54
54.01	RADIOLOGY-ULTRASOUND	485					2,966,726	54.01
60	Laboratory	1,708		11			16,546,991	60
62	Whole Blood & Packed Red Blood Cells	110					396,149	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,532		6	12,321		1,361,181	65
66	Physical Therapy	10,023		13			4,271,418	66
69	Electrocardiology	272					751,497	69
71	Medical Supplies Charged to Patients	1,515					1,118,287	71
72	Impl. Dev. Charged to Patients	529					332,515	72
73	Drugs Charged to Patients					629,031	6,967,723	73
76	CARDIAC REHAB	2,298					200,485	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	18,273		34				88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic	13,633		14				90
90.01	PAIN MANAGEMENT CLINIC	754		1			33,854	90.01
91	Emergency	9,600	1,406	15	30,395		9,215,067	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	450		8	17,272			101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	122,277	42,818	215	231,802	629,031	79,676,117	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	700						190
192	Physicians' Private Offices			1				192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS	1,996						194.01
194.02	FOUNDATION SERVICES	50						194.02
194.03	WELLNESS	3,490		5				194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross foot adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	NURSING ADMINIS-TRATION NURSING HOURS	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		9	10	11	13	15	16	
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	766,235	766,995	571,939	916,932	3,659,878	1,067,529	202
203	Unit Cost Multiplier (Wkst. B, Part I)	5.962315	17.912910	2,587.959276	3.955669	5.818279	0.013398	203
204	Cost to be allocated (Per Wkst. B, Part II)	32,132	130,783	59,511	29,124	194,612	109,953	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.250029	3.054393	269.280543	0.125642	0.309384	0.001380	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME						
		17						

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	NONPATIENT TELEPHONES							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING RECEIVING AND STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING/ACCOUNTS RECEIVABLE							5.05
5.06	OTHER ADMINISTRATIVE AND GENERAL							5.06
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service	100						17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	67						30
43	Nursery							43
44	Skilled Nursing Facility	30						44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency	2						91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency	1						101
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS							194.01
194.02	FOUNDATION SERVICES							194.02
194.03	WELLNESS							194.03
194.04	RENTED SPACE							194.04

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME						
		17						
194.05	LITIGATION COSTS							194.05
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	97,024						202
203	Unit Cost Multiplier (Wkst. B, Part I)	970.240000						203
204	Cost to be allocated (Per Wkst. B, Part II)	3,928						204
205	Unit Cost Multiplier (Wkst. B, Part II)	39.280000						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	5,116,107		5,116,107		5,116,107	30
43	Nursery	199,519		199,519		199,519	43
44	Skilled Nursing Facility	3,023,079		3,023,079		3,023,079	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,517,039		4,517,039		4,517,039	50
52	Delivery Room & Labor Room	308,026		308,026		308,026	52
53	Anesthesiology						53
54	Radiology-Diagnostic	3,181,855		3,181,855		3,181,855	54
54.01	RADIOLOGY-ULTRASOUND	429,768		429,768		429,768	54.01
60	Laboratory	3,061,123		3,061,123		3,061,123	60
62	Whole Blood & Packed Red Blood Cells	157,554		157,554		157,554	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	965,590		965,590		965,590	65
66	Physical Therapy	2,568,528		2,568,528		2,568,528	66
69	Electrocardiology	78,639		78,639		78,639	69
71	Medical Supplies Charged to Patients	632,596		632,596		632,596	71
72	Impl. Dev. Charged to Patients	207,289		207,289		207,289	72
73	Drugs Charged to Patients	4,107,103		4,107,103		4,107,103	73
76	CARDIAC REHAB	183,077		183,077		183,077	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	5,683,900		5,683,900		5,683,900	88
88.01	RHC II	514,456		514,456		514,456	88.01
88.02	RHC III	1,053,604		1,053,604		1,053,604	88.02
90	Clinic	3,697,640		3,697,640		3,697,640	90
90.01	PAIN MANAGEMENT CLINIC	208,487		208,487		208,487	90.01
91	Emergency	3,137,486		3,137,486		3,137,486	91
92	Observation Beds (Non-Distinct Part)	480,282		480,282		480,282	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	890,265		890,265		890,265	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	44,403,012		44,403,012		44,403,012	200
201	Less Observation Beds	480,282		480,282		480,282	201
202	Total (line 200 minus line 201)	43,922,730		43,922,730		43,922,730	202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	4,600,937		4,600,937				30
43	Nursery	540,692		540,692				43
44	Skilled Nursing Facility	1,205,444		1,205,444				44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,320,734	10,136,969	12,457,703	0.362590	0.362590	0.362590	50
52	Delivery Room & Labor Room	255,220	75,953	331,173	0.930106	0.930106	0.930106	52
53	Anesthesiology							53
54	Radiology-Diagnostic	1,038,592	16,545,585	17,584,177	0.180950	0.180950	0.180950	54
54.01	RADIOLOGY-ULTRASOUND	261,582	2,705,144	2,966,726	0.144863	0.144863	0.144863	54.01
60	Laboratory	1,566,165	14,980,826	16,546,991	0.184996	0.184996	0.184996	60
62	Whole Blood & Packed Red Blood Cells	196,858	199,291	396,149	0.397714	0.397714	0.397714	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	469,358	891,823	1,361,181	0.709377	0.709377	0.709377	65
66	Physical Therapy	882,088	3,389,330	4,271,418	0.601329	0.601329	0.601329	66
69	Electrocardiology	65,604	685,893	751,497	0.104643	0.104643	0.104643	69
71	Medical Supplies Charged to Patients	468,595	649,692	1,118,287	0.565683	0.565683	0.565683	71
72	Impl. Dev. Charged to Patients	139,937	192,578	332,515	0.623397	0.623397	0.623397	72
73	Drugs Charged to Patients	1,630,760	5,336,963	6,967,723	0.589447	0.589447	0.589447	73
76	CARDIAC REHAB	825	200,931	201,756	0.907418	0.907418	0.907418	76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		6,183,609	6,183,609				88
88.01	RHC II		499,847	499,847				88.01
88.02	RHC III		1,088,850	1,088,850				88.02
90	Clinic	11,793	2,195,716	2,207,509	1.675028	1.675028	1.675028	90
90.01	PAIN MANAGEMENT CLINIC		33,854	33,854	6.158416	6.158416	6.158416	90.01
91	Emergency	305,446	8,909,621	9,215,067	0.340473	0.340473	0.340473	91
92	Observation Beds (Non-Distinct Part)	7,183	482,353	489,536	0.981096	0.981096	0.981096	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency		622,351	622,351				101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	15,967,813	76,007,179	91,974,992				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	15,967,813	76,007,179	91,974,992				202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	5,116,107		5,116,107		5,116,107	30
43	Nursery	199,519		199,519		199,519	43
44	Skilled Nursing Facility	3,023,079		3,023,079		3,023,079	44
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	4,517,039		4,517,039		4,517,039	50
52	Delivery Room & Labor Room	308,026		308,026		308,026	52
53	Anesthesiology						53
54	Radiology-Diagnostic	3,181,855		3,181,855		3,181,855	54
54.01	RADIOLOGY-ULTRASOUND	429,768		429,768		429,768	54.01
60	Laboratory	3,061,123		3,061,123		3,061,123	60
62	Whole Blood & Packed Red Blood Cells	157,554		157,554		157,554	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	965,590		965,590		965,590	65
66	Physical Therapy	2,568,528		2,568,528		2,568,528	66
69	Electrocardiology	78,639		78,639		78,639	69
71	Medical Supplies Charged to Patients	632,596		632,596		632,596	71
72	Impl. Dev. Charged to Patients	207,289		207,289		207,289	72
73	Drugs Charged to Patients	4,107,103		4,107,103		4,107,103	73
76	CARDIAC REHAB	183,077		183,077		183,077	76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	5,683,900		5,683,900		5,683,900	88
88.01	RHC II	514,456		514,456		514,456	88.01
88.02	RHC III	1,053,604		1,053,604		1,053,604	88.02
90	Clinic	3,697,640		3,697,640		3,697,640	90
90.01	PAIN MANAGEMENT CLINIC	208,487		208,487		208,487	90.01
91	Emergency	3,137,486		3,137,486		3,137,486	91
92	Observation Beds (Non-Distinct Part)	480,282		480,282		480,282	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
101	Home Health Agency	890,265		890,265		890,265	101
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	44,403,012		44,403,012		44,403,012	200
201	Less Observation Beds	480,282		480,282		480,282	201
202	Total (line 200 minus line 201)	43,922,730		43,922,730		43,922,730	202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

		CHARGES						
COST CENTER DESCRIPTIONS		Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
ANCILLARY SERVICE COST CENTERS								
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
OTHER REIMBURSABLE COST CENTERS								
101	Home Health Agency							101
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	4,517,039	975,700	3,541,339		50
52	Delivery Room & Labor Room	308,026	42,050	265,976		52
53	Anesthesiology					53
54	Radiology-Diagnostic	3,181,855	426,039	2,755,816		54
54.01	RADIOLOGY-ULTRASOUND	429,768	34,563	395,205		54.01
60	Laboratory	3,061,123	187,901	2,873,222		60
62	Whole Blood & Packed Red Blood Cells	157,554	7,183	150,371		62
62.30	BLOOD CLOTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	965,590	87,985	877,605		65
66	Physical Therapy	2,568,528	334,884	2,233,644		66
69	Electrocardiology	78,639	11,963	66,676		69
71	Medical Supplies Charged to Patients	632,596	59,263	573,333		71
72	Impl. Dev. Charged to Patients	207,289	20,556	186,733		72
73	Drugs Charged to Patients	4,107,103	234,871	3,872,232		73
76	CARDIAC REHAB	183,077	77,051	106,026		76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	5,683,900	86,076	5,597,824		88
88.01	RHC II	514,456	5,796	508,660		88.01
88.02	RHC III	1,053,604	32,663	1,020,941		88.02
90	Clinic	3,697,640	452,412	3,245,228		90
90.01	PAIN MANAGEMENT CLINIC	208,487	27,210	181,277		90.01
91	Emergency	3,137,486	411,314	2,726,172		91
92	Observation Beds (Non-Distinct Part)	480,282	58,502	421,780		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency	890,265	16,251	874,014		101
113	Interest Expense					113
200	Subtotal	36,064,307	3,590,233	32,474,074		200
201	Less Observation Beds	480,282	58,502	421,780		201
202	Total	35,584,025	3,531,731	32,052,294		202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		4,517,039			50
52	Delivery Room & Labor Room		308,026			52
53	Anesthesiology					53
54	Radiology-Diagnostic		3,181,855			54
54.01	RADIOLOGY-ULTRASOUND		429,768			54.01
60	Laboratory		3,061,123			60
62	Whole Blood & Packed Red Blood Cells		157,554			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		965,590			65
66	Physical Therapy		2,568,528			66
69	Electrocardiology		78,639			69
71	Medical Supplies Charged to Patients		632,596			71
72	Impl. Dev. Charged to Patients		207,289			72
73	Drugs Charged to Patients		4,107,103			73
76	CARDIAC REHAB		183,077			76
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic		5,683,900			88
88.01	RHC II		514,456			88.01
88.02	RHC III		1,053,604			88.02
90	Clinic		3,697,640			90
90.01	PAIN MANAGEMENT CLINIC		208,487			90.01
91	Emergency		3,137,486			91
92	Observation Beds (Non-Distinct Part)		480,282	489,536	0.981096	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
101	Home Health Agency		890,265			101
113	Interest Expense					113
200	Subtotal		36,064,307	489,536		200
201	Less Observation Beds		480,282	489,536		201
202	Total		35,584,025			202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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 [XX] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
 Boxes: [] Title XIX - O/P [] IRF [] NF [] ICF/IID

(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.)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.362590		2,955,912			1,071,784		50
52	Delivery Room & Labor Room	0.930106							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.180950		6,111,031			1,105,791		54
54.01	RADIOLOGY-ULTRASOUND	0.144863		512,218			74,201		54.01
60	Laboratory	0.184996		6,419,073			1,187,503		60
62	Whole Blood & Packed Red Blood	0.397714		115,815			46,061		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.709377		286,436			203,191		65
66	Physical Therapy	0.601329		1,145,092			688,577		66
69	Electrocardiology	0.104643		653,526			68,387		69
71	Medical Supplies Charged to Pat	0.565683		131,214			74,226		71
72	Impl. Dev. Charged to Patients	0.623397		120,513			75,127		72
73	Drugs Charged to Patients	0.589447		2,001,276			1,179,646		73
76	CARDIAC REHAB	0.907418		13,803			12,525		76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.675028		811,353			1,359,039		90
90.01	PAIN MANAGEMENT CLINIC	6.158416							90.01
91	Emergency	0.340473		2,015,899			686,359		91
92	Observation Beds (Non-Distinct	0.981096		241,108			236,550		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			23,534,269			8,068,967		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			23,534,269			8,068,967		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z343

WORKSHEET D
PART V

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

(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	0.362590							50
52	Delivery Room & Labor Room	0.930106							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.180950							54
54.01	RADIOLOGY-ULTRASOUND	0.144863							54.01
60	Laboratory	0.184996							60
62	Whole Blood & Packed Red Blood	0.397714							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.709377							65
66	Physical Therapy	0.601329							66
69	Electrocardiology	0.104643							69
71	Medical Supplies Charged to Pat	0.565683							71
72	Impl. Dev. Charged to Patients	0.623397							72
73	Drugs Charged to Patients	0.589447							73
76	CARDIAC REHAB	0.907418							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.675028							90
90.01	PAIN MANAGEMENT CLINIC	6.158416							90.01
91	Emergency	0.340473							91
92	Observation Beds (Non-Distinct	0.981096							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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/IID ☒ PPS
Applicable ☒ Title XVIII, Part A ☐ IPF ☒ SNF ☐ TEFRA
Boxes: ☐ Title XIX ☐ IRF ☐ NF ☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-ULTRASOUND									54.01
60	Laboratory									60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76	CARDIAC REHAB									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
88.01	RHC II									88.01
88.02	RHC III									88.02
90	Clinic									90
90.01	PAIN MANAGEMENT CLINIC									90.01
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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/IID [XX] PPS
Applicable [XX] Title XVIII, Part A [] IPF [XX] SNF [] TEFRA
Boxes: [] Title XIX [] IRF [] NF [] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	12,457,703							50
52	Delivery Room & Labor Room	331,173							52
53	Anesthesiology								53
54	Radiology-Diagnostic	17,584,177			23,307				54
54.01	RADIOLOGY-ULTRASOUND	2,966,726			3,905				54.01
60	Laboratory	16,546,991			62,805				60
62	Whole Blood & Packed Red Blood	396,149			3,143				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,361,181			78,005				65
66	Physical Therapy	4,271,418			399,453				66
69	Electrocardiology	751,497			4,729				69
71	Medical Supplies Charged to Pat	1,118,287			15,484				71
72	Impl. Dev. Charged to Patients	332,515							72
73	Drugs Charged to Patients	6,967,723			16,179				73
76	CARDIAC REHAB	201,756							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	6,183,609							88
88.01	RHC II	499,847							88.01
88.02	RHC III	1,088,850							88.02
90	Clinic	2,207,509							90
90.01	PAIN MANAGEMENT CLINIC	33,854							90.01
91	Emergency	9,215,067							91
92	Observation Beds (Non-Distinct	489,536							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	85,005,568			607,010				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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/IID

(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.)	
	ANCILLARY SERVICE COST CENTERS	1	2	3	4	5	6	7	
50	Operating Room	0.362590							50
52	Delivery Room & Labor Room	0.930106							52
53	Anesthesiology								53
54	Radiology-Diagnostic	0.180950							54
54.01	RADIOLOGY-ULTRASOUND	0.144863							54.01
60	Laboratory	0.184996							60
62	Whole Blood & Packed Red Blood	0.397714							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.709377							65
66	Physical Therapy	0.601329							66
69	Electrocardiology	0.104643							69
71	Medical Supplies Charged to Pat	0.565683							71
72	Impl. Dev. Charged to Patients	0.623397							72
73	Drugs Charged to Patients	0.589447							73
76	CARDIAC REHAB	0.907418							76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic	1.675028							90
90.01	PAIN MANAGEMENT CLINIC	6.158416							90.01
91	Emergency	0.340473							91
92	Observation Beds (Non-Distinct	0.981096							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	623,184	92,349	530,835	3,076	172.57	455	78,519	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	23,296		23,296	366	63.65	67	4,265	43
44	Skilled Nursing Facility	195,099		195,099	6,864	28.42			44
45	Nursing Facility								45
200	Total (lines 30-199)	841,579		749,230	10,306		522	82,784	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	975,700	12,457,703	0.078321			50
52	Delivery Room & Labor Room	42,050	331,173	0.126973			52
53	Anesthesiology						53
54	Radiology-Diagnostic	426,039	17,584,177	0.024229			54
54.01	RADIOLOGY-ULTRASOUND	34,563	2,966,726	0.011650			54.01
60	Laboratory	187,901	16,546,991	0.011356			60
62	Whole Blood & Packed Red Blood	7,183	396,149	0.018132			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	87,985	1,361,181	0.064639			65
66	Physical Therapy	334,884	4,271,418	0.078401			66
69	Electrocardiology	11,963	751,497	0.015919			69
71	Medical Supplies Charged to Pat	59,263	1,118,287	0.052994			71
72	Impl. Dev. Charged to Patients	20,556	332,515	0.061820			72
73	Drugs Charged to Patients	234,871	6,967,723	0.033708			73
76	CARDIAC REHAB	77,051	201,756	0.381902			76
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	86,076	6,183,609	0.013920			88
88.01	RHC II	5,796	499,847	0.011596			88.01
88.02	RHC III	32,663	1,088,850	0.029998			88.02
90	Clinic	452,412	2,207,509	0.204942			90
90.01	PAIN MANAGEMENT CLINIC	27,210	33,854	0.803745			90.01
91	Emergency	411,314	9,215,067	0.044635			91
92	Observation Beds (Non-Distinct	58,502	489,536	0.119505			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,573,982	85,005,568				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ PPS
☐ TEFRA
☐ Other

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ PPS
☐ TEFRA
☐ 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)	3,076		455		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	366		67		43
44	Skilled Nursing Facility	6,864				44
45	Nursing Facility					45
200	Total (lines 30-199)	10,306		522		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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/IID ☒ PPS
 Applicable ☐ Title XVIII, Part A ☐ IPF ☐ SNF ☐ TEFRA
 Boxes: ☒ Title XIX ☐ IRF ☐ NF ☐ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
54.01	RADIOLOGY-ULTRASOUND									54.01
60	Laboratory									60
62	Whole Blood & Packed Red Blood									62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
76	CARDIAC REHAB									76
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
88.01	RHC II									88.01
88.02	RHC III									88.02
90	Clinic									90
90.01	PAIN MANAGEMENT CLINIC									90.01
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1343

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☒ PPS
☐ TEFRA
☐ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
54.01	RADIOLOGY-ULTRASOUND								54.01
60	Laboratory								60
62	Whole Blood & Packed Red Blood								62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
76	CARDIAC REHAB								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic								90
90.01	PAIN MANAGEMENT CLINIC								90.01
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
54.01	RADIOLOGY-ULTRASOUND								54.01
60	Laboratory								60
62	Whole Blood & Packed Red Blood								62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
76	CARDIAC REHAB								76
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
88.01	RHC II								88.01
88.02	RHC III								88.02
90	Clinic								90
90.01	PAIN MANAGEMENT CLINIC								90.01
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

Check ☐ **Title V - I/P** ☒ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☐ **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)	3,621	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,076	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	2,737	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	356	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)	178	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	4	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,197	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)	350	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)	175	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	144.67	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	5,116,107	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)	1,013	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	590	25
26	Total swing-bed cost (see instructions)	758,153	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,357,954	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	4,357,954	37

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,416.76 38
39	Program general inpatient routine service cost (line 9 x line 38)						1,695,862 39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)						1,695,862 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)						1,619,521 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						3,315,383 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)						495,866 64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						247,933 65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						743,799 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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					339	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,416.76	88
89	Observation bed cost (line 87 x line 88) (see instructions)					480,282	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	623,184	5,116,107	0.121808	480,282	58,502	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

Check ☐ **Title V - I/P** ☐ **Hospital** ☐ **SUB (Other)** ☐ **ICF/IID** ☒ **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)	6,864	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,864	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)	6,864	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,152	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	3,023,079	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)	3,023,079	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,023,079	37

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

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

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

70	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	3,023,079	70
71	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	440.43	71
72	Program routine service cost (line 9 x line 71)	507,375	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)	507,375	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)	507,375	83
84	Program inpatient ancillary services (see instructions)	331,981	84
85	Utilization review - physician compensation (see instructions)		85
86	Total Program inpatient operating costs (sum of lines 83 through 85)	839,356	86

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

Check ☐ Title V - I/P ☒ Hospital ☐ SUB (Other) ☐ ICF/IID ☒ 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)	3,621	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,076	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	2,737	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	356	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)	178	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	4	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	455	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)	366	15
16	Nursery days (title V or XIX only)	67	16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	144.67	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	5,116,107	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)	1,013	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	590	25
26	Total swing-bed cost (see instructions)	758,153	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,357,954	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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)	4,357,954	37

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,416.76	38
39	Program general inpatient routine service cost (line 9 x line 38)						644,626	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)						644,626	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)	199,519	366	545.13	67	36,524		42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47
							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)							48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						681,150	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						82,784	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)						82,784	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						598,366	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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1343

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☒ PPS

☐ TEFRA

☐ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					339	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,416.76	88
89	Observation bed cost (line 87 x line 88) (see instructions)					480,282	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	623,184	5,116,107	0.121808	480,282	58,502	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,671,373		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.362590	848,164	307,536	50
52	Delivery Room & Labor Room	0.930106			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.180950	745,321	134,866	54
54.01	RADIOLOGY-ULTRASOUND	0.144863	44,178	6,400	54.01
60	Laboratory	0.184996	737,307	136,399	60
62	Whole Blood & Packed Red Blood Cells	0.397714	125,670	49,981	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.709377	298,482	211,736	65
66	Physical Therapy	0.601329	158,507	95,315	66
69	Electrocardiology	0.104643	37,415	3,915	69
71	Medical Supplies Charged to Patients	0.565683	284,779	161,095	71
72	Impl. Dev. Charged to Patients	0.623397	88,512	55,178	72
73	Drugs Charged to Patients	0.589447	682,613	402,364	73
76	CARDIAC REHAB	0.907418			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.675028	5,960	9,983	90
90.01	PAIN MANAGEMENT CLINIC	6.158416			90.01
91	Emergency	0.340473	113,627	38,687	91
92	Observation Beds (Non-Distinct Part)	0.981096	6,183	6,066	92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		4,176,718	1,619,521	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		4,176,718		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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/IID ☒ Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.362590	3,759	1,363	50
52	Delivery Room & Labor Room	0.930106			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.180950	20,838	3,771	54
54.01	RADIOLOGY-ULTRASOUND	0.144863	1,518	220	54.01
60	Laboratory	0.184996	85,944	15,899	60
62	Whole Blood & Packed Red Blood Cells	0.397714	8,266	3,288	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.709377	32,251	22,878	65
66	Physical Therapy	0.601329	162,359	97,631	66
69	Electrocardiology	0.104643	3,707	388	69
71	Medical Supplies Charged to Patients	0.565683	45,851	25,937	71
72	Impl. Dev. Charged to Patients	0.623397			72
73	Drugs Charged to Patients	0.589447	183,424	108,119	73
76	CARDIAC REHAB	0.907418			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.675028	797	1,335	90
90.01	PAIN MANAGEMENT CLINIC	6.158416			90.01
91	Emergency	0.340473			91
92	Observation Beds (Non-Distinct Part)	0.981096			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		548,714	280,829	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		548,714		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-6150

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.362590			50
52	Delivery Room & Labor Room	0.930106			52
53	Anesthesiology				53
54	Radiology-Diagnostic	0.180950	23,307	4,217	54
54.01	RADIOLOGY-ULTRASOUND	0.144863	3,905	566	54.01
60	Laboratory	0.184996	62,805	11,619	60
62	Whole Blood & Packed Red Blood Cells	0.397714	3,143	1,250	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.709377	78,005	55,335	65
66	Physical Therapy	0.601329	399,453	240,203	66
69	Electrocardiology	0.104643	4,729	495	69
71	Medical Supplies Charged to Patients	0.565683	15,484	8,759	71
72	Impl. Dev. Charged to Patients	0.623397			72
73	Drugs Charged to Patients	0.589447	16,179	9,537	73
76	CARDIAC REHAB	0.907418			76
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
88.01	RHC II				88.01
88.02	RHC III				88.02
90	Clinic	1.675028			90
90.01	PAIN MANAGEMENT CLINIC	6.158416			90.01
91	Emergency	0.340473			91
92	Observation Beds (Non-Distinct Part)	0.981096			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		607,010	331,981	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		607,010		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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)	8,068,967			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	8,068,967			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 (see instructions)	8,149,657			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	74,414			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	3,364,735			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)	4,710,508			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)	4,710,508			30
31	Primary payer payments	1,013			31
32	Subtotal (line 30 minus line 31)	4,709,495			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)	321,215			34
35	Adjusted reimbursable bad debts (see instructions)	208,790			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	151,020			36
37	Subtotal (see instructions)	4,918,285			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)	4,918,285			40
40.01	Sequestration adjustment (see instructions)	98,366			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	4,789,600			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	30,319			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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over 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 (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			2,744,518		4,789,600
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					
3	List separately each retroactive lump sum adjustment	.01				3.01
	amount based on subsequent revision of the interim	.02				3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99				3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			2,744,518		4,789,600
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment	.01				5.01
	after desk review. Also show date of each payment.	.02				5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		231,903		30,319
		.02				6.02
7	Total Medicare program liability (see instructions)			2,976,421		4,819,919
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			954,621		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			954,621		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		.01	44,004		6.01
			.02			6.02
7	Total Medicare program liability (see instructions)			998,625		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			372,484		1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			372,484		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determined net settlement amount (balance due)		.01	1,353		6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)			373,837		7
8	Name of Contractor	Contractor Number			NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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)	751,237		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	283,637		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	525		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)	1,034,874		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,034,874		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,034,874		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	18,142		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)	1,016,732		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)	3,497		17
17.01	Adjusted reimbursable bad debts (see instructions)	2,273		17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,497		18
19	Total (see instructions)	1,019,005		19
19.01	Sequestration adjustment (see instructions)	20,380		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	954,621		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	44,004		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	3,315,383	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	3,315,383	4
5	Primary payer payments		5
6	Total cost (see instructions)	3,348,537	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)	3,348,537	19
20	Deductibles (exclude professional component)	331,440	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	3,017,097	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	3,017,097	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,872	25
26	Adjusted reimbursable bad debts (see instructions)	20,067	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	11,129	27
28	Subtotal (sum of lines 24 and 26)	3,037,164	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	3,037,164	30
30.01	Sequestration adjustment (see instructions)	60,743	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	2,744,518	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	231,903	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	470,638	1
2	Routine service other pass through costs		2
3	Ancillary service other pass through costs		3
4	Subtotal (sum of lines 1-3)	470,638	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	90,552	7
8	Allowable bad debts (see instructions)	2,123	8
9	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		9
10	Adjusted reimbursable bad debts (see instructions)	1,380	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)	381,466	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)	381,466	15
15.01	Sequestration adjustment (see instructions)	7,629	15.01
15.02	Demonstration payment adjustment amount after sequestration		15.02
16	Interim payments	372,484	16
17	Tentative settlement (for contractor use only)		17
18	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16 and 17)	1,353	18
19	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		19

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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/IID ☐ 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			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)			4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a 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)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)			38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)			40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

BALANCE SHEET**WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	4,883,341				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	11,349,318				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-3,100,000				6
7	Inventory	1,083,995				7
8	Prepaid expenses	854,353				8
9	Other current assets	289,882				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	15,360,889				11
	FIXED ASSETS					
12	Land	540,645				12
13	Land improvements	1,282,487				13
14	Accumulated depreciation	-688,382				14
15	Buildings	53,668,293				15
16	Accumulated depreciation	-21,784,557				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	18,740,077				23
24	Accumulated depreciation	-12,262,892				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	39,495,671				30
	OTHER ASSETS					
31	Investments	23,258,469				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	4,708,423				34
35	Total other assets (sum of lines 31-34)	27,966,892				35
36	Total assets (sum of lines 11, 30 and 35)	82,823,452				36
	Liabilities and Fund Balances					
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,362,535				37
38	Salaries, wages and fees payable	3,071,690				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)					40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	953,178				44
45	Total current liabilities (sum of lines 37 thru 44)	5,387,403				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	24,641,311				47
48	Unsecured loans					48
49	Other long term liabilities	4,475,441				49
50	Total long term liabilities (sum of lines 46 thru 49)	29,116,752				50
51	Total liabilities (sum of lines 45 and 50)	34,504,155				51
	CAPITAL ACCOUNTS					
52	General fund balance	48,319,297				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)	48,319,297				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	82,823,452				60

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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		49,485,948		1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,166,651		2
3	Total (sum of line 1 and line 2)		48,319,297		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)		48,319,297		11
12	Deductions (debit adjustments) (specify)				12
13	TRANSFER PERM RESTRICTED				13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		48,319,297		19

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	5,019,683		5,019,683	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	60,982		60,982	5
6	Swing Bed - NF				6
7	Skilled nursing facility	1,206,747		1,206,747	7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	6,287,412		6,287,412	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)	6,287,412		6,287,412	17
18	Ancillary services	11,200,236	67,673,824	78,874,060	18
19	Outpatient services		8,105,668	8,105,668	19
20	Rural Health Clinic (RHC)		6,184,155	6,184,155	20
20.01	RHC II		499,847	499,847	20.01
20.02	RHC III		1,075,850	1,075,850	20.02
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency		622,351	622,351	22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	PHYSICIAN PRIVATE OFFICE		8,253	8,253	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	17,487,648	84,169,948	101,657,596	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		50,682,248	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	RECONCILING ITEM			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)		50,682,248	43

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	101,657,596	1
2	Less contractual allowances and discounts on patients' accounts	53,712,704	2
3	Net patient revenues (line 1 minus line 2)	47,944,892	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	50,682,248	4
5	Net income from service to patients (line 3 minus line 4)	-2,737,356	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	40,535	6
7	Income from investments	222,739	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	149,629	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	25,169	17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space	234,861	22
23	Governmental appropriations		23
24	Other (CONSULTING CLINIC)	84,888	24
24.01	Other (WELLNESS)	53,081	24.01
24.02	Other (GRANTS)		24.02
24.03	Other (MEANING FULL USE)		24.03
24.04	Other (FOUNDATION REIMBURSEMENT)		24.04
24.05	Other (DONATIONS)		24.05
24.06	Other (OTHER INCOME)	644,704	24.06
24.07	Other (TAX SUPPORT)	115,099	24.07
25	Total other income (sum of lines 6-24)	1,570,705	25
26	Total (line 5 plus line 25)	-1,166,651	26
29	Net income (or loss) for the period (line 26 minus line 28)	-1,166,651	29

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	125,640	8,167	68	10,367	26,113	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	302,332	19,652	12,859			6
7	Physical Therapy	27,853	1,810	6,296			7
8	Occupational Therapy	6,430	411	1,180			8
9	Speech Pathology	83		261			9
10	Medical Social Services						10
11	Home Health Aide	25,404	1,651	5,790			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)	487,742	31,691	26,454	10,367	26,113	24

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	170,355	9,828	180,183		180,183	5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care	334,843		334,843		334,843	6
7	Physical Therapy	35,959		35,959		35,959	7
8	Occupational Therapy	8,021		8,021		8,021	8
9	Speech Pathology	344		344		344	9
10	Medical Social Services						10
11	Home Health Aide	32,845		32,845		32,845	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)	582,367	9,828	592,195		592,195	24

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General	180,183				5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care	334,843				6
7	Physical Therapy	35,959				7
8	Occupational Therapy	8,021				8
9	Speech Pathology	344				9
10	Medical Social Services					10
11	Home Health Aide	32,845				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)	592,195				24

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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		180,183	180,183		5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care		334,843	146,435	481,278	6
7	Physical Therapy		35,959	15,726	51,685	7
8	Occupational Therapy		8,021	3,508	11,529	8
9	Speech Pathology		344	150	494	9
10	Medical Social Services					10
11	Home Health Aide		32,845	14,364	47,209	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)		592,195		592,195	24

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

COST ALLOCATION - HHA STATISTICAL BASIS
HHA CCN: 14-7175
**WORKSHEET H-1
PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT- ATION (Mileage)	RECONCIL- IATION	ADMINI- STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General					-180,183	412,012	5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care						334,843	6
7	Physical Therapy						35,959	7
8	Occupational Therapy						8,021	8
9	Speech Pathology						344	9
10	Medical Social Services							10
11	Home Health Aide						32,845	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)					-180,183	412,012	24
25	Cost To Be Allocated (per Worksheet H-1, Part I)						180,183	25
26	Unit Cost Multiplier						0.437325	26

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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			1,843	23,928	718		1
2	Skilled Nursing Care	481,278			57,577			2
3	Physical Therapy	51,685			5,305			3
4	Occupational Therapy	11,529			1,225			4
5	Speech Pathology	494			16			5
6	Medical Social Services							6
7	Home Health Aide	47,209			4,838			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)	592,195		1,843	92,889	718		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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	HHA COST CENTER (omit cents)	PURCHASING RECEIVING AND STORE	ADMITTING	CASHIERING /ACCOUNTS RECEIVABLE	SUBTOTAL (cols.0-4)	OTHER ADMI NISTRATIVE AND GENER	MAIN- TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	Administrative and General	911		20,249	47,649	5,968		1
2	Skilled Nursing Care				538,855	67,495		2
3	Physical Therapy				56,990	7,138		3
4	Occupational Therapy				12,754	1,597		4
5	Speech Pathology				510	64		5
6	Medical Social Services							6
7	Home Health Aide				52,047	6,519		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)	911		20,249	708,805	88,781		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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7175

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	MAIN- TENANCE OF PERSONNEL	
		7	8	9	10	11	12	
1	Administrative and General			2,683		20,704		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)			2,683		20,704		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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	HHA COST CENTER (omit cents)	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		13	14	15	16	17	19	
1	Administrative and General	68,322				970		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)	68,322				970		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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	HHA COST CENTER (omit cents)	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP- DOWN ADJS	
		20	21	22	23	24	25	
1	Administrative and General					146,296		1
2	Skilled Nursing Care					606,350		2
3	Physical Therapy					64,128		3
4	Occupational Therapy					14,351		4
5	Speech Pathology					574		5
6	Medical Social Services							6
7	Home Health Aide					58,566		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)					890,265		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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	HHA COST CENTER (omit cents)	SUBTOTAL (cols 23 +/- 24) 26	ALLOCATED HHA A&G (see PtlI) 27	TOTAL HHA COSTS 28				
1	Administrative and General	146,296						1
2	Skilled Nursing Care	606,350	119,234	725,584				2
3	Physical Therapy	64,128	12,610	76,738				3
4	Occupational Therapy	14,351	2,822	17,173				4
5	Speech Pathology	574	113	687				5
6	Medical Social Services							6
7	Home Health Aide	58,566	11,517	70,083				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)	890,265	146,296	890,265				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.		0.196643					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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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		1,833	125,640	9		14,076	1
2	Skilled Nursing Care			302,332				2
3	Physical Therapy			27,853				3
4	Occupational Therapy			6,430				4
5	Speech Pathology			83				5
6	Medical Social Services							6
7	Home Health Aide			25,404				7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		1,833	487,742	9		14,076	20
21	Total cost to be allocated		1,843	92,889	718		911	21
22	Unit Cost Multiplier			0.190447				22
22	Unit Cost Multiplier		1.005456		79.777778		0.064720	22

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	HHA COST CENTER	ADMITTING INPATIENT REVENUE	CASHIERING /ACCOUNTS RECEIVABLE GROSS REVENUE	RECON- CILIATION	OTHER ADMI- NISTRATIVE AND GENER ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	
		5.04	5.05	4A.06	5.06	6	7	
1	Administrative and General		622,351		47,649			1
2	Skilled Nursing Care				538,855			2
3	Physical Therapy				56,990			3
4	Occupational Therapy				12,754			4
5	Speech Pathology				510			5
6	Medical Social Services							6
7	Home Health Aide				52,047			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)		622,351		708,805			20
21	Total cost to be allocated		20,249		88,781			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		0.032536		0.125254			22

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	HHA COST CENTER	LAUNDRY & LINEN SERVICE POUNDS	HOUSE- KEEPING SQUARE FEET	DIETARY MEALS	CAFETERIA FTE'S	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION NURSING HOURS	
		8	9	10	11	12	13	
1	Administrative and General		450		8		17,272	1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)		450		8		17,272	20
21	Total cost to be allocated		2,683		20,704		68,322	21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier		5.962222		2,588.000000		3.955651	22

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

	HHA COST CENTER	CENTRAL SERVICES & SUPPLY CSS CSTED REQ'	PHARMACY RX CSTD REQ'S	MEDICAL RECORDS & LIBRARY GROSS REVENUE	SOCIAL SERVICE TIME	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	
		14	15	16	17	19	20	
1	Administrative and General				1			1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)				1			20
21	Total cost to be allocated				970			21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier				970.000000			22

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7175

**WORKSHEET H-2
PART II**

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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	725,584		725,584	1,554	466.91	1
2	Physical Therapy	3	76,738		76,738	817	93.93	2
3	Occupational Therapy	4	17,173		17,173	165	104.08	3
4	Speech Pathology	5	687		687	31	22.16	4
5	Medical Social Services	6						5
6	Home Health Aide	7	70,083		70,083	506	138.50	6
7	Total (sum of lines 1-6)		890,265		890,265	3,073		7

Limitation Cost Computation						
				Program Visits		
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	99914		1,334		8
9	Physical Therapy	99914		703		9
10	Occupational Therapy	99914		132		10
11	Speech Pathology	99914		26		11
12	Medical Social Services	99914				12
13	Home Health Aide	99914		265		13
14	Total (sum of lines 8-13)			2,460		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		11,174	11,174	19,753	0.565686	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	0.601329			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	0.565683	19,753	11,174	col. 2, line 15	4
5	Drugs Charged to Patients	73	0.589447			col. 2, line 16	5

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

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				
		Part B			Part B			Total Program Cost (sum of cols 9-10)	
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		6	7	8	9	10	11	12	
1	Skilled Nursing Care		1,334			622,858		622,858	1
2	Physical Therapy		703			66,033		66,033	2
3	Occupational Therapy		132			13,739		13,739	3
4	Speech Pathology		26			576		576	4
5	Medical Social Services								5
6	Home Health Aide		265			36,703		36,703	6
7	Total (sum of lines 1-6)		2,460			739,909		739,909	7

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT**HHA CCN: 14-7175****WORKSHEET H-4
PARTS I & II**Check applicable box: ☐ Title V ☒ Title XVIII ☐ Title XIX**PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES**

		Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
	Description	1	2	3
	Reasonable Cost of Part A & Part B Services			
1	Reasonable cost of services (see instructions)			1
2	Total charges			2
	Customary Charges			
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)			3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)			4
5	Ratio of line 3 to line 4 (not to 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		332,545	11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes		9,669	13
14	Total PPS Reimbursement - PEP Episodes		2,939	14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PSP Episodes		16,410	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)		361,563	22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)		361,563	24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)		361,563	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)		361,563	29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)		361,563	31
31.01	Sequestration adjustment (see instructions)		8,399	31.01
31.02	Demonstration payment adjustment amount after sequestration			31.02
32	Interim payments (see instructions)		353,164	32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

WORKSHEET H-5

			Part A		Part B		
DESCRIPTION			mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1	Total interim payments paid to provider					353,164	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)					353,164	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				6.01
			.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)					353,164	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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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 (see instructions)		6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)		7
8	Percentage of Medicaid patient days to total days (see instructions)		8
9	Sum of lines 7 and 8		9
10	Allowable disproportionate share percentage (see instructions)		10
11	Disproportionate share adjustment (see instructions)		11
12	Total prospective capital payments (see instructions)		12

PART II - PAYMENT UNDER REASONABLE COST

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

PART III - COMPUTATION OF EXCEPTION PAYMENTS

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
43	Nursery							43
44	Skilled Nursing Facility							44
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
54.01	RADIOLOGY-ULTRASOUND							54.01
60	Laboratory							60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	CARDIAC REHAB							76
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
88.01	RHC II							88.01
88.02	RHC III							88.02
90	Clinic							90
90.01	PAIN MANAGEMENT CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
101	Home Health Agency							101
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.10	PHYSICIAN HOSPITALIST							192.10
194	NONREIMBURSEABLE							194
194.01	PROFESSIONAL BUILDINGS							194.01
194.02	FOUNDATION SERVICES							194.02
194.03	WELLNESS							194.03
194.04	RENTED SPACE							194.04
194.05	LITIGATION COSTS							194.05
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	--------------------------------	--	--

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	2,241,416		2,241,416	-23,727	2,217,689	-56,246	2,161,443	1
2	Physician Assistant								2
3	Nurse Practitioner	130,963		130,963		130,963		130,963	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	1,043,509	184,508	1,228,017		1,228,017		1,228,017	9
10	Subtotal (sum of lines 1 through 9)	3,415,888	184,508	3,600,396	-23,727	3,576,669	-56,246	3,520,423	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		202,632	202,632		202,632		202,632	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment				174,142	174,142		174,142	17
18	Professional Liability Insurance								18
19	Other Health Care Costs		13,198	13,198		13,198		13,198	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		215,830	215,830	174,142	389,972		389,972	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,415,888	400,338	3,816,226	150,415	3,966,641	-56,246	3,910,395	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		113,206	113,206		113,206		113,206	29
30	Administrative Costs		169,944	169,944		169,944		169,944	30
31	Total Facility Overhead (sum of lines 29 and 30)		283,150	283,150		283,150		283,150	31
32	Total facility costs (sum of lines 22, 28 and 31)	3,415,888	683,488	4,099,376	150,415	4,249,791	-56,246	4,193,545	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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

Check applicable box: ☒ RHC **I** ☐ FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	5.00	23,225	4,200	21,000		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.23	4,110	2,100	2,583		3
4	Subtotal (sum of lines 1 through 3)	6.23	27,335		23,583	27,335	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)	6.23	27,335			27,335	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)	3,910,395	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)	3,910,395	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)	283,150	14
15	Parent provider overhead allocated to facility (see instructions)	1,490,355	15
16	Total overhead (sum of lines 14 and 15)	1,773,505	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,773,505	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,773,505	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	5,683,900	20

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

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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)	5,683,900	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	226,894	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	5,457,006	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	27,335	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	27,335	6
7	Adjusted cost per visit (line 3 divided by line 6)	199.63	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)	199.63	199.63	199.63	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		6,910		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		1,379,443		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)		1,379,443		16
16.01	Total program charges (see instructions)(from contractor's records)		1,172,630		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		123,976		16.02
16.03	Total program preventive costs (see instructions)		145,842		16.03
16.04	Total program non-preventive costs (see instructions)		888,119		16.04
16.05	Total program cost (see instructions)		1,033,961		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		123,452		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		185,040		19
20	Net Medicare cost excluding vaccines (see instructions)		1,033,961		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		165,009		21
22	Total reimbursable Program cost (line 20 plus line 21)		1,198,970		22
23	Allowable bad debts (see instructions)		47,602		23
23.01	Adjusted reimbursable bad debts (see instructions)		30,941		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		1,229,911		26
26.01	Sequestration adjustment (see instructions)		24,598		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		1,024,522		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		180,791		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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3429

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,520,423	3,520,423	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000854	0.019730	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	3,006	69,458	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	70,875	12,760	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	73,881	82,218	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	3,910,395	3,910,395	6
7	Total overhead (from Wkst. M-2, line 16)	1,773,505	1,773,505	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.018893	0.021025	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	33,507	37,288	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	107,388	119,506	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	405	794	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	265.16	150.51	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	284	596	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	75,305	89,704	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		226,894	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		165,009	16

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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 ☐ FQHC

			Part B		
DESCRIPTION			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider			1,024,522	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			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)			1,024,522	
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		180,791	6.01
		.02			6.02
7	Total Medicare program liability (see instructions)			1,205,313	
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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

**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**

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner	123,863		123,863		123,863		123,863	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	155,363	18,725	174,088		174,088	-1,587	172,501	9
10	Subtotal (sum of lines 1 through 9)	279,226	18,725	297,951		297,951	-1,587	296,364	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		20,765	20,765		20,765		20,765	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment				8,241	8,241		8,241	17
18	Professional Liability Insurance								18
19	Other Health Care Costs		5,220	5,220		5,220		5,220	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		25,985	25,985	8,241	34,226		34,226	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	279,226	44,710	323,936	8,241	332,177	-1,587	330,590	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		20,727	20,727		20,727		20,727	29
30	Administrative Costs		49,800	49,800		49,800		49,800	30
31	Total Facility Overhead (sum of lines 29 and 30)		70,527	70,527		70,527		70,527	31
32	Total facility costs (sum of lines 22, 28 and 31)	279,226	115,237	394,463	8,241	402,704	-1,587	401,117	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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

Check applicable box: ☒ **RHC II** ☐ **FQHC**

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians			4,200			1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.83	2,929	2,100	1,743		3
4	Subtotal (sum of lines 1 through 3)	0.83	2,929		1,743	2,929	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	0.83	2,929			2,929	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)		330,590	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)		330,590	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)		70,527	14
15	Parent provider overhead allocated to facility (see instructions)		113,339	15
16	Total overhead (sum of lines 14 and 15)		183,866	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		183,866	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		183,866	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)		514,456	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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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)	514,456	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	25,680	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	488,776	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	2,929	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	2,929	6
7	Adjusted cost per visit (line 3 divided by line 6)	166.87	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)	166.87	166.87	166.87	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		535		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		89,275		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)		89,275		16
16.01	Total program charges (see instructions)(from contractor's records)		93,077		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		15,823		16.02
16.03	Total program preventive costs (see instructions)		15,177		16.03
16.04	Total program non-preventive costs (see instructions)		49,395		16.04
16.05	Total program cost (see instructions)		64,572		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		12,354		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,980		19
20	Net Medicare cost excluding vaccines (see instructions)		64,572		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		23,962		21
22	Total reimbursable Program cost (line 20 plus line 21)		88,534		22
23	Allowable bad debts (see instructions)		3,404		23
23.01	Adjusted reimbursable bad debts (see instructions)		2,213		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		90,747		26
26.01	Sequestration adjustment (see instructions)		1,815		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		46,718		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		42,214		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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	296,364	296,364	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000295	0.002405	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	87	713	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	14,175	1,527	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	14,262	2,240	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	330,590	330,590	6
7	Total overhead (from Wkst. M-2, line 16)	183,866	183,866	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.043141	0.006776	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,932	1,246	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	22,194	3,486	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	81	95	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	274.00	36.69	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	75	93	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	20,550	3,412	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		25,680	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		23,962	16

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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 1	Amount 2	
1	Total interim payments paid to provider			46,718	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			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)			46,718	
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		42,214	6.01
		.02			6.02
7	Total Medicare program liability (see instructions)			88,932	
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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

**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

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	218,859		218,859	10,481	229,340	-4,678	224,662	1
2	Physician Assistant								2
3	Nurse Practitioner	129,376		129,376		129,376		129,376	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	247,602	42,194	289,796		289,796		289,796	9
10	Subtotal (sum of lines 1 through 9)	595,837	42,194	638,031	10,481	648,512	-4,678	643,834	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		31,996	31,996		31,996		31,996	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment				73,633	73,633		73,633	17
18	Professional Liability Insurance								18
19	Other Health Care Costs		2,767	2,767		2,767		2,767	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		34,763	34,763	73,633	108,396		108,396	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	595,837	76,957	672,794	84,114	756,908	-4,678	752,230	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		46,689	46,689		46,689		46,689	29
30	Administrative Costs		10,444	10,444		10,444		10,444	30
31	Total Facility Overhead (sum of lines 29 and 30)		57,133	57,133		57,133		57,133	31
32	Total facility costs (sum of lines 22, 28 and 31)	595,837	134,090	729,927	84,114	814,041	-4,678	809,363	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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

Check applicable box: ☒ RHC III ☐ FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.86	2,145	4,200	3,612		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	0.85	3,668	2,100	1,785		3
4	Subtotal (sum of lines 1 through 3)	1.71	5,813		5,397	5,813	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)	1.71	5,813			5,813	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)	752,230	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)	752,230	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)	57,133	14
15	Parent provider overhead allocated to facility (see instructions)	244,241	15
16	Total overhead (sum of lines 14 and 15)	301,374	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	301,374	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	301,374	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	1,053,604	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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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)	1,053,604	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	5,345	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,048,259	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	5,813	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	5,813	6
7	Adjusted cost per visit (line 3 divided by line 6)	180.33	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)	180.33	180.33	180.33	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		962		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		173,477		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)		173,477		16
16.01	Total program charges (see instructions)(from contractor's records)		161,188		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,056		16.02
16.03	Total program preventive costs (see instructions)		6,518		16.03
16.04	Total program non-preventive costs (see instructions)		123,947		16.04
16.05	Total program cost (see instructions)		130,465		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		12,025		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		28,621		19
20	Net Medicare cost excluding vaccines (see instructions)		130,465		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,345		21
22	Total reimbursable Program cost (line 20 plus line 21)		135,810		22
23	Allowable bad debts (see instructions)		8,155		23
23.01	Adjusted reimbursable bad debts (see instructions)		5,301		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		141,111		26
26.01	Sequestration adjustment (see instructions)		2,822		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		97,612		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		40,677		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.

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	643,834	643,834	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000890	0.001564	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	573	1,007	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,400	836	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,973	1,843	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	752,230	752,230	6
7	Total overhead (from Wkst. M-2, line 16)	301,374	301,374	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002623	0.002450	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	791	738	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,764	2,581	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	8	52	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	345.50	49.63	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	8	52	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,764	2,581	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		5,345	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		5,345	16

KPMG LLP Compu-Max 2552-10

CRAWFORD MEMORIAL HOSPITAL Provider CCN: 14-1343	In Lieu of Form CMS-2552-10	Period : From: 05/01/2018 To: 04/30/2019	Run Date: 09/28/2019 Run Time: 11:00 Version: 2018.12 (08/29/2019)
---	---------------------------------------	--	--

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

			Part B		
DESCRIPTION			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider			97,612	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero				2
3	List separately each retroactive lump sum adjustment		.01		3.01
	amount based on subsequent revision of the interim		.02		3.02
	rate for the cost reporting period. Also show date of	Program	.03		3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04		3.04
		Provider	.05		3.05
			.06		3.06
			.07		3.07
			.08		3.08
			.09		3.09
			.10		3.10
			.50		3.50
			.51		3.51
		Provider	.52		3.52
		to	.53		3.53
		Program	.54		3.54
			.55		3.55
			.56		3.56
			.57		3.57
			.58		3.58
			.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			97,612	
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01		5.01
	after desk review. Also show date of each payment.		.02		5.02
	If none, write 'NONE' or enter zero (1)	Program	.03		5.03
		to	.04		5.04
		Provider	.05		5.05
			.06		5.06
			.07		5.07
			.08		5.08
			.09		5.09
			.10		5.10
			.50		5.50
			.51		5.51
		Provider	.52		5.52
		to	.53		5.53
		Program	.54		5.54
			.55		5.55
			.56		5.56
			.57		5.57
			.58		5.58
			.59		5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99		5.99
6	Determine net settlement amount (balance due)		.01	40,677	6.01
	based on the cost report (1)		.02		6.02
7	Total Medicare program liability (see instructions)			138,289	
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.