LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/22/2016 Time: 17:52 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAWRENCE COUNTY MEMORIAL HOSPITAL (14-1344) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2015 and ending 06/30/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		373,388	-139,383	452,815		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		104,869				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-29,615			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		478,257	-168,998	452,815		200

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 2100 STATE STREET	P.O. Box:		1
2	City: LAWRENCEVILLE	State: IL	ZIP Code: 62439	County: LAWRENCE 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	LAWRENCE COUNTY MEMORIAL HOSPITAL	14-1344	99914	1	04 / 01 / 2005	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	LAWRENCE COUNTY MEMORIAL HOSPITAL	14-Z344	99914		04 / 01 / 2005	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	LCMH PRIMARY CARE CLINIC	14-3499	99914		03 / 26 / 2009	N	O	N	15
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: 07 / 01 / 2015	To: 06 / 30 / 2016	20
21	Type of control (see instructions)	2		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.	2	N		23

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

Inpatient Psychiatric Faciltiy PPS

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

Inpatient Rehabilitation Facility PPS

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

Long Term Care Hospital PPS

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

TEFRA Providers

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

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

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

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

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		Y		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1		118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	195,479			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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

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WORKSHEET S-2
PART I

All Providers

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

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

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

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	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)	473,321		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)		07 / 01 / 2015 06 / 30 / 2016	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N	171

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/31/2016	Y	10/31/2016	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

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

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	N	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.	Y	35

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

Cost Report Preparer Contact Information				
41	First name: BRENT	Last name: KOCHEL	Title: MANAGER	41
42	Employer: KEB			42
43	Phone number: 618-529-1040	E-mail Address: BRENTK@KEBCPA.COM		43

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,150	51,312.00		1,521	304	2,138	1
2	HMO and other (see instructions)						64			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						500		500	5
6	Hospital Adults & Peds. Swing Bed NF								2	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,150	51,312.00		2,021	304	2,640	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,150	51,312.00		2,021	304	2,640	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								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								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					5,207	8,118	21,352	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							16	113	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								9	30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					364	100	574	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)		117.07			364	100	574	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		19.78						26
27	Total (sum of lines 14-26)		136.85						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N	/ /	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				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				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).			201

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

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-3499** **WORKSHEET S-8**
STATISTICAL DATA

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

Clinic Address and Identification:

1	Street: 2111 LEXINGTON	1
2	City: LAWRENCEVILLE State: IL ZIP Code: 62439 County: LAWRENCE	2
3	FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.375836	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,746,580	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH or supplemental payments from Medicaid	1,505,438	5
6	Medicaid charges	11,208,084	6
7	Medicaid cost (line 1 times line 6)	4,212,401	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundnig charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,279,113	443,570	1,722,683	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	480,737	166,710	647,447	21
22	Partial payment by patients approved for charity care	107,854	58,108	165,962	22
23	Cost of charity care (line 21 minus line 22)	372,883	108,602	481,485	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, enter charges for patient days beyond an indigent care program's length of stay limit (see instructions)		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,098,795	26
27	Medicare bad debts for the entire hospital complex (see instructions)	123,495	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	975,300	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	366,553	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	848,038	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	848,038	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		499,960	499,960		499,960		499,960	1
2	00200	Cap Rel Costs-Mvble Equip		556,667	556,667		556,667	-341,468	215,199	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	973	1,745,436	1,746,409	39,574	1,785,983	-30,431	1,755,552	4
5.01	00580	ADMINISTRATIVE & GENERAL	335,155	297,086	632,241		632,241	-8,400	623,841	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	69,911	25,885	95,796		95,796	-28,332	67,464	5.02
5.03	01160	COMMUNICATIONS		55,699	55,699		55,699		55,699	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	376,496	1,434,193	1,810,689	-47,074	1,763,615	-36,806	1,726,809	5.04
6	00600	Maintenance & Repairs	178,963	160,279	339,242		339,242		339,242	6
7	00700	Operation of Plant		177,072	177,072		177,072		177,072	7
8	00800	Laundry & Linen Service		112,165	112,165		112,165		112,165	8
9	00900	Housekeeping	197,870	27,051	224,921		224,921		224,921	9
10	01000	Dietary	197,544	210,765	408,309	-341,283	67,026		67,026	10
11	01100	Cafeteria				341,283	341,283	-120,492	220,791	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	163,966	11,473	175,439		175,439		175,439	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	204,300	11,533	215,833		215,833		215,833	15
16	01600	Medical Records & Library	234,912	124,728	359,640		359,640	-8,205	351,435	16
17	01700	Social Service				33,970	33,970		33,970	17
19	01900	Nonphysician Anesthetists		3,578	3,578	106,655	110,233		110,233	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	1,001,629	113,916	1,115,545	-33,970	1,081,575		1,081,575	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	237,327	315,410	552,737	-25,616	527,121		527,121	50
53	05300	Anesthesiology	207,127	20,152	227,279	-106,655	120,624	-107,986	12,638	53
54	05400	Radiology-Diagnostic	255,691	517,382	773,073		773,073		773,073	54
57	05700	CT Scan	19,508	97,722	117,230		117,230		117,230	57
58	05800	MRI		185,674	185,674		185,674		185,674	58
60	06000	Laboratory	497,547	413,921	911,468		911,468	-33,160	878,308	60
62	06200	Whole Blood & Packed Red Blood Cells		61,765	61,765		61,765		61,765	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	170,218	26,307	196,525		196,525	-528	195,997	65
66	06600	Physical Therapy	151,029	22,592	173,621		173,621		173,621	66
66.01	06601	CARDIAC REHAB	13,880	1,060	14,940		14,940	-255	14,685	66.01
67	06700	Occupational Therapy	82,280	893	83,173		83,173		83,173	67
68	06800	Speech Pathology	8,660		8,660		8,660		8,660	68
71	07100	Medical Supplies Charged to Patients		31,888	31,888		31,888		31,888	71
72	07200	Impl. Dev. Charged to Patients				25,616	25,616		25,616	72
73	07300	Drugs Charged to Patients		216,643	216,643		216,643		216,643	73
76	03020	OTHER ANCILLARY SERVICE COST CENTER								76
76.01	03950	OCCUPATIONAL MEDICINE	49,018	6,447	55,465	720	56,185	-6,029	50,156	76.01
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	1,496,048	172,027	1,668,075	20,836	1,688,911	-80,126	1,608,785	88
90	09000	Clinic	81,572	418,116	499,688		499,688	-407,206	92,482	90
91	09100	Emergency	417,660	1,163,564	1,581,224	-720	1,580,504	-199,243	1,381,261	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	6,649,284	9,239,049	15,888,333	13,336	15,901,669	-1,408,667	14,493,002	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		27,237	27,237	-13,336	13,901		13,901	192
200		TOTAL (sum of lines 118-199)	6,649,284	9,266,286	15,915,570		15,915,570	-1,408,667	14,506,903	200

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RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	CAFETERIA RECLASS	A	Cafeteria	11	165,116	176,167	1
500	Total reclassifications				165,116	176,167	500
	Code Letter - A						
1	EMPLOYEE BENEFIT RECLASS	B	Employee Benefits Department	4	39,574		1
500	Total reclassifications				39,574		500
	Code Letter - B						
1	RHC UTILITIES RECLASS	C	Rural Health Clinic	88		13,336	1
500	Total reclassifications					13,336	500
	Code Letter - C						
1	SALARIES RECLASS	D					1
500	Total reclassifications						500
	Code Letter - D						
1	SALARIES RECLASS	E	Social Service	17	33,970		1
500	Total reclassifications				33,970		500
	Code Letter - E						
1	IMPLANT DEVICE COST RECLASS	F	Impl. Dev. Charged to Patient	72		25,616	1
500	Total reclassifications					25,616	500
	Code Letter - F						
1	CRNA RECLASS	G	Nonphysician Anesthetists	19	106,655		1
500	Total reclassifications				106,655		500
	Code Letter - G						
1	SPEECH THERAPY RECLASS	H					1
500	Total reclassifications						500
	Code Letter - H						
1	DR. CARR OCCUP MED RECLASS	I	OCCUPATIONAL MEDICINE	76.01	720		1
500	Total reclassifications				720		500
	Code Letter - I						
1	RHC DR CLAGETT SIGN ON	J	Rural Health Clinic	88	7,500		1
500	Total reclassifications				7,500		500
	Code Letter - J						
	GRAND TOTAL (Increases)				353,535	215,119	

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

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RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	CAFETERIA RECLASS	A	Dietary	10	165,116	176,167		1
500	Total reclassifications				165,116	176,167		500
	Code letter - A							
1	EMPLOYEE BENEFIT RECLASS	B	OTHER ADMINISTRATIVE AND GENE	5.04	39,574			1
500	Total reclassifications				39,574			500
	Code letter - B							
1	RHC UTILITIES RECLASS	C	Physicians' Private Offices	192		13,336		1
500	Total reclassifications					13,336		500
	Code letter - C							
1	SALARIES RECLASS	D						1
500	Total reclassifications							500
	Code letter - D							
1	SALARIES RECLASS	E	Adults & Pediatrics	30	33,970			1
500	Total reclassifications				33,970			500
	Code letter - E							
1	IMPLANT DEVICE COST RECLASS	F	Operating Room	50		25,616		1
500	Total reclassifications					25,616		500
	Code letter - F							
1	CRNA RECLASS	G	Anesthesiology	53	106,655			1
500	Total reclassifications				106,655			500
	Code letter - G							
1	SPEECH THERAPY RECLASS	H						1
500	Total reclassifications							500
	Code letter - H							
1	DR. CARR OCCUP MED RECLASS	I	Emergency	91	720			1
500	Total reclassifications				720			500
	Code letter - I							
1	RHC DR CLAGETT SIGN ON	J	OTHER ADMINISTRATIVE AND GENE	5.04	7,500			1
500	Total reclassifications				7,500			500
	Code letter - J							
	GRAND TOTAL (Decreases)				353,535	215,119		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	20,150					20,150		1
2	Land Improvements	573,091					573,091		2
3	Buildings and Fixtures	9,425,553	146,525		146,525		9,572,078		3
4	Building Improvements								4
5	Fixed Equipment	735,328					735,328		5
6	Movable Equipment	5,123,350	787,600		787,600		5,910,950		6
7	HIT-designated Assets	788,373	473,322		473,322		1,261,695		7
8	Subtotal (sum of lines 1-7)	16,665,845	1,407,447		1,407,447		18,073,292		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	16,665,845	1,407,447		1,407,447		18,073,292		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	440,405			54,683	4,872		499,960	1
2	Cap Rel Costs-Mvble Equip	519,858		36,809				556,667	2
3	Total (sum of lines 1-2)	960,263		36,809	54,683	4,872		1,056,627	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	10,900,647		10,900,647	0.603136					1
2	Cap Rel Costs-Mvble Equ	7,172,645		7,172,645	0.396864					2
3	Total (sum of lines 1-2)	18,073,292		18,073,292	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	440,405			54,683	4,872		499,960	1
2	Cap Rel Costs-Mvble Equip	185,921		29,278				215,199	2
3	Total (sum of lines 1-2)	626,326		29,278	54,683	4,872		715,159	3

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

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ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)	B	-7,411	Cap Rel Costs-Mvble Equip	2	11	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)	B	-28,332	PURCHASING RECEIVING AND STORES	5.02		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	-664,808				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	-120,492	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-8,205	Medical Records & Library	16		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-333,937	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYSICIAN MALPRACTICE COSTS	A	-36,934	Emergency	91		33
34	PHYSICIAN MALPRACTICE COSTS	A	-52,665	Clinic	90		34
35	DONATIONS EXPENSE	A	-9,230	OTHER ADMINISTRATIVE AND GENERAL	5.04		35
36	MISC REVENUE - ADMIN	A	-3,279	OTHER ADMINISTRATIVE AND GENERAL	5.04		36
37	PHYSICIAN RECURITMENT	A	-1,753	OTHER ADMINISTRATIVE AND GENERAL	5.04		37
38	TELEPHONE OFFSET	A	-120	Cap Rel Costs-Mvble Equip	2	11	38
39	TELEPHONE OFFSET	A	-2,087	OTHER ADMINISTRATIVE AND GENERAL	5.04		39
40	TELEPHONE OFFSET	A	-567	Employee Benefits Department	4		40
41	LOBBYING EXPENSE	A	-6,748	OTHER ADMINISTRATIVE AND GENERAL	5.04		41
42	PART B PHYSICIAN BILING COSTS	A	-8,400	ADMINISTRATIVE & GENERAL	5.01		42
43	ADVERTISING - ADMIN	A	-13,709	OTHER ADMINISTRATIVE AND GENERAL	5.04		43
44	CRNA BENEFITS	A	-29,864	Employee Benefits Department	4		44
45							45
46	COST OF RHC DOCS IN HOSPITAL	A	-80,126	Rural Health Clinic	88		46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,408,667				50

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

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

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STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS **WORKSHEET A-8-1**

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

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

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

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

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

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

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

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

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

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

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	91	Emergency EMERGENCY	997,182	162,309	834,873					1
2	90	Clinic CLINIC	354,541	354,541						2
3	60	Laboratory LABORATORY	33,160	33,160						3
4	65	Respiratory Therapy RESPIRATORY THE	528	528						4
5	66.01	CARDIAC REHAB CARDIAC REHAB	255	255						5
6	76.01	OCCUPATIONAL MEDICIN OCCUPATIONAL ME	6,029	6,029						6
7	53	Anesthesiology CRNA	107,672	107,672						7
8	53	Anesthesiology CRNA	314	314						8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,499,681	664,808	834,873					200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	91	Emergency EMERGENCY							162,309	1
2	90	Clinic CLINIC							354,541	2
3	60	Laboratory LABORATORY							33,160	3
4	65	Respiratory Therapy RESPIRATORY THE							528	4
5	66.01	CARDIAC REHAB CARDIAC REHAB							255	5
6	76.01	OCCUPATIONAL MEDICIN OCCUPATIONAL ME							6,029	6
7	53	Anesthesiology CRNA							107,672	7
8	53	Anesthesiology CRNA							314	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							664,808	200

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					365	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					3.25	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		88.00				9
10	AHSEA (see instructions)		71.89				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)	35.95	35.95				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)	6,326	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)	6,326	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)	6,326	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)	71.89	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	56,074	22
23	Total salary equivalency (see instructions)	56,074	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)	13,122	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)	13,122	26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	1,186	27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	14,308	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)	14,308	33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	56,074	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)	14,308	58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	70,382	63
64	Total cost of outside supplier services (from provider records)	6,389	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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	ADMIN & GENERAL	PURCHASING RECEIVING AND STORES	
		0	1	2	4	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	499,960	499,960					1
2	Cap Rel Costs-Mvble Equip	215,199		215,199				2
4	Employee Benefits Department	1,755,552			1,755,552			4
5.01	ADMINISTRATIVE & GENERAL	623,841	13,409	11,990	90,491	739,731		5.01
5.02	PURCHASING RECEIVING AND STORES	67,464	4,390		18,876		90,730	5.02
5.03	COMMUNICATIONS	55,699					308	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	1,726,809	36,740	28,591	90,968		4,607	5.04
6	Maintenance & Repairs	339,242			48,320		2,310	6
7	Operation of Plant	177,072	99,816	4,432			33	7
8	Laundry & Linen Service	112,165						8
9	Housekeeping	224,921	5,735	940	53,425		1,823	9
10	Dietary	67,026	6,480	349	8,534		2,047	10
11	Cafeteria	220,791	15,051	1,832	44,803		10,747	11
12	Maintenance of Personnel							12
13	Nursing Administration	175,439	1,996		44,270		308	13
14	Central Services & Supply							14
15	Pharmacy	215,833	2,981		55,161		467	15
16	Medical Records & Library	351,435	9,916	5,312	63,426		108	16
17	Social Service	33,970	316		9,172		20	17
19	Nonphysician Anesthetists	110,233			27,127			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	1,081,575	79,043	31,535	261,266	34,162	7,396	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	527,121	61,049	47,448	64,078	95,035	11,693	50
53	Anesthesiology	12,638	354	5,557		9,944	1,101	53
54	Radiology-Diagnostic	773,073	7,832	25,948	69,036	84,866	4,248	54
57	CT Scan	117,230	5,337	19,286	5,267	83,384	263	57
58	MRI	185,674	3,341			32,212		58
60	Laboratory	878,308	7,023	17,538	134,337	139,639	16,123	60
62	Whole Blood & Packed Red Blood Cells	61,765	1,200			7,151	498	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	195,997	5,665	3,840	45,959	18,088	1,505	65
66	Physical Therapy	173,621	9,436	2,457	40,778	17,896	1,415	66
66.01	CARDIAC REHAB	14,685	2,564	865	3,748	722	11	66.01
67	Occupational Therapy	83,173			22,215	7,836	56	67
68	Speech Pathology	8,660			2,338	684		68
71	Medical Supplies Charged to Patients	31,888	3,190			15,159	2,806	71
72	Impl. Dev. Charged to Patients	25,616				2,063		72
73	Drugs Charged to Patients	216,643		190		39,021	14,606	73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE	50,156			13,235	389	24	76.01
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	1,608,785	60,929	2,877	403,931	54,062	3,176	88
90	Clinic	92,482	16,920	799	22,024	5,392	420	90
91	Emergency	1,381,261	15,044	2,270	112,767	92,026	2,135	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	14,493,002	475,757	214,056	1,755,552	739,731	90,254	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	13,901	24,203	1,143			476	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	14,506,903	499,960	215,199	1,755,552	739,731	90,730	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	COMMUNICAT	SUBTOTAL (cols.0-4)	OTHER ADMINISTRA & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	4A	5.04	6	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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS	56,007						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	4,773	1,892,488	1,892,488				5.04
6	Maintenance & Repairs		389,872	58,491	448,363			6
7	Operation of Plant	3,182	284,535	42,688	100,475	427,698		7
8	Laundry & Linen Service		112,165	16,828			128,993	8
9	Housekeeping	318	287,162	43,082	5,773	9,417		9
10	Dietary	1,591	86,027	12,906	6,523	10,640	753	10
11	Cafeteria		293,224	43,991	15,150	24,713		11
12	Maintenance of Personnel							12
13	Nursing Administration	2,546	224,559	33,690	2,009	3,277		13
14	Central Services & Supply							14
15	Pharmacy		274,442	41,173	3,001	4,895		15
16	Medical Records & Library	5,092	435,289	65,305	9,981	16,282		16
17	Social Service	955	44,433	6,666	318	519		17
19	Nonphysician Anesthetists		137,360	20,608				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	8,910	1,503,887	225,622	79,565	129,789	53,733	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,864	809,288	121,414	61,453	100,243	23,401	50
53	Anesthesiology	318	29,912	4,488	356	581		53
54	Radiology-Diagnostic	1,273	966,276	144,967	7,883	12,860	10,537	54
57	CT Scan	318	231,085	34,669	5,372	8,763	4,021	57
58	MRI	318	221,545	33,238	3,363	5,486	1,554	58
60	Laboratory	1,909	1,194,877	179,263	7,070	11,532		60
62	Whole Blood & Packed Red Blood Cells		70,614	10,594	1,208	1,970		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,591	272,645	40,904	5,703	9,303	535	65
66	Physical Therapy	636	246,239	36,942	9,498	15,494	6,753	66
66.01	CARDIAC REHAB	636	23,231	3,485	2,581	4,211	49	66.01
67	Occupational Therapy		113,280	16,995				67
68	Speech Pathology		11,682	1,753				68
71	Medical Supplies Charged to Patients		53,043	7,958	3,211	5,237		71
72	Impl. Dev. Charged to Patients		27,679	4,153				72
73	Drugs Charged to Patients	636	271,096	40,671				73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE		63,804	9,572				76.01
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	12,413	2,146,173	321,977	61,332			88
90	Clinic	2,546	140,583	21,091	17,032	27,783		90
91	Emergency	3,182	1,608,685	241,345	15,144	24,703	27,129	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	56,007	14,467,180	1,886,529	424,001	427,698	128,465	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		39,723	5,959	24,362		528	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	56,007	14,506,903	1,892,488	448,363	427,698	128,993	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	345,434						9
10	Dietary	6,453	123,302					10
11	Cafeteria	33,894		410,972				11
12	Maintenance of Personnel							12
13	Nursing Administration	3,152		8,682	275,369			13
14	Central Services & Supply							14
15	Pharmacy	1,965		8,852		334,328		15
16	Medical Records & Library	2,781		28,768			558,406	16
17	Social Service			6,852				17
19	Nonphysician Anesthetists			4,256				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	69,273	123,302	94,561	156,731		350,840	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	52,510		21,108	34,977		176,339	50
53	Anesthesiology			170				53
54	Radiology-Diagnostic	7,565		9,788				54
57	CT Scan	7,454		9,575				57
58	MRI	2,855		3,745				58
60	Laboratory	15,946		48,047				60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,710		13,831			31,227	65
66	Physical Therapy	6,490		10,682	17,728			66
66.01	CARDIAC REHAB	7,380		4,724				66.01
67	Occupational Therapy			4,085				67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients					334,328		73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE							76.01
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	32,337		84,178				88
90	Clinic	16,094		9,277				90
91	Emergency	43,647		39,791	65,933			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	314,506	123,302	410,972	275,369	334,328	558,406	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	30,928						192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	345,434	123,302	410,972	275,369	334,328	558,406	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	19	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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
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	58,788						17
19	Nonphysician Anesthetists		162,224					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	58,788		2,846,091		2,846,091		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			1,400,733		1,400,733		50
53	Anesthesiology		162,224	197,731		197,731		53
54	Radiology-Diagnostic			1,159,876		1,159,876		54
57	CT Scan			300,939		300,939		57
58	MRI			271,786		271,786		58
60	Laboratory			1,456,735		1,456,735		60
62	Whole Blood & Packed Red Blood Cells			84,386		84,386		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			378,858		378,858		65
66	Physical Therapy			349,826		349,826		66
66.01	CARDIAC REHAB			45,661		45,661		66.01
67	Occupational Therapy			134,360		134,360		67
68	Speech Pathology			13,435		13,435		68
71	Medical Supplies Charged to Patients			69,449		69,449		71
72	Impl. Dev. Charged to Patients			31,832		31,832		72
73	Drugs Charged to Patients			646,095		646,095		73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE			73,376		73,376		76.01
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			2,645,997		2,645,997		88
90	Clinic			231,860		231,860		90
91	Emergency			2,066,377		2,066,377		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	58,788	162,224	14,405,403		14,405,403		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			101,500		101,500		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	58,788	162,224	14,506,903		14,506,903		202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMIN & GENERAL	PURCHASING RECEIVING AND STORES	
		0	1	2	2A	5.01	5.02	
	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	ADMINISTRATIVE & GENERAL		13,409	11,990	25,399	25,399		5.01
5.02	PURCHASING RECEIVING AND STORES		4,390		4,390		4,390	5.02
5.03	COMMUNICATIONS						15	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL		36,740	28,591	65,331		223	5.04
6	Maintenance & Repairs						112	6
7	Operation of Plant		99,816	4,432	104,248		2	7
8	Laundry & Linen Service							8
9	Housekeeping		5,735	940	6,675		88	9
10	Dietary		6,480	349	6,829		99	10
11	Cafeteria		15,051	1,832	16,883		520	11
12	Maintenance of Personnel							12
13	Nursing Administration		1,996		1,996		15	13
14	Central Services & Supply							14
15	Pharmacy		2,981		2,981		23	15
16	Medical Records & Library		9,916	5,312	15,228		5	16
17	Social Service		316		316		1	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		79,043	31,535	110,578	1,174	358	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		61,049	47,448	108,497	3,265	566	50
53	Anesthesiology		354	5,557	5,911	342	53	53
54	Radiology-Diagnostic		7,832	25,948	33,780	2,915	206	54
57	CT Scan		5,337	19,286	24,623	2,864	13	57
58	MRI		3,341		3,341	1,107		58
60	Laboratory		7,023	17,538	24,561	4,785	778	60
62	Whole Blood & Packed Red Blood Cells		1,200		1,200	246	24	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,665	3,840	9,505	621	73	65
66	Physical Therapy		9,436	2,457	11,893	615	68	66
66.01	CARDIAC REHAB		2,564	865	3,429	25	1	66.01
67	Occupational Therapy					269	3	67
68	Speech Pathology					23		68
71	Medical Supplies Charged to Patients		3,190		3,190	521	136	71
72	Impl. Dev. Charged to Patients					71		72
73	Drugs Charged to Patients			190	190	1,340	707	73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE					13	1	76.01
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		60,929	2,877	63,806	1,857	154	88
90	Clinic		16,920	799	17,719	185	20	90
91	Emergency		15,044	2,270	17,314	3,161	103	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		475,757	214,056	689,813	25,399	4,367	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		24,203	1,143	25,346		23	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		499,960	215,199	715,159	25,399	4,390	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	COMMUNICAT	OTHER ADMINISTRA & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	
		5.03	5.04	6	7	8	9	
	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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS	15						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	1	65,555					5.04
6	Maintenance & Repairs		2,026	2,138				6
7	Operation of Plant	1	1,479	479	106,209			7
8	Laundry & Linen Service		583			583		8
9	Housekeeping		1,492	28	2,338		10,621	9
10	Dietary		447	31	2,642	3	198	10
11	Cafeteria		1,524	72	6,137		1,042	11
12	Maintenance of Personnel							12
13	Nursing Administration	1	1,167	10	814		97	13
14	Central Services & Supply							14
15	Pharmacy		1,426	14	1,216		60	15
16	Medical Records & Library	1	2,262	48	4,043		86	16
17	Social Service		231	2	129			17
19	Nonphysician Anesthetists		714					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	7,816	379	32,231	243	2,129	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1	4,206	293	24,893	106	1,615	50
53	Anesthesiology		155	2	144			53
54	Radiology-Diagnostic		5,022	38	3,193	48	233	54
57	CT Scan		1,201	26	2,176	18	229	57
58	MRI		1,151	16	1,362	7	88	58
60	Laboratory	1	6,210	34	2,864		490	60
62	Whole Blood & Packed Red Blood Cells		367	6	489			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,417	27	2,310	2	145	65
66	Physical Therapy		1,280	45	3,848	31	200	66
66.01	CARDIAC REHAB		121	12	1,046		227	66.01
67	Occupational Therapy		589					67
68	Speech Pathology		61					68
71	Medical Supplies Charged to Patients		276	15	1,301			71
72	Impl. Dev. Charged to Patients		144					72
73	Drugs Charged to Patients		1,409					73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE		332					76.01
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	11,150	292			994	88
90	Clinic	1	731	81	6,899		495	90
91	Emergency	1	8,360	72	6,134	123	1,342	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	15	65,349	2,022	106,209	581	9,670	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		206	116		2	951	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	15	65,555	2,138	106,209	583	10,621	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10	11	13	15	16	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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	10,249						10
11	Cafeteria		26,178					11
12	Maintenance of Personnel							12
13	Nursing Administration		553	4,653				13
14	Central Services & Supply							14
15	Pharmacy		564		6,284			15
16	Medical Records & Library		1,832			23,505		16
17	Social Service		436				1,115	17
19	Nonphysician Anesthetists		271					19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	10,249	6,024	2,648		14,768	1,115	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		1,345	591		7,423		50
53	Anesthesiology		11					53
54	Radiology-Diagnostic		623					54
57	CT Scan		610					57
58	MRI		239					58
60	Laboratory		3,060					60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		881			1,314		65
66	Physical Therapy		680	300				66
66.01	CARDIAC REHAB		301					66.01
67	Occupational Therapy		260					67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients				6,284			73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE							76.01
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		5,362					88
90	Clinic		591					90
91	Emergency		2,535	1,114				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	10,249	26,178	4,653	6,284	23,505	1,115	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,249	26,178	4,653	6,284	23,505	1,115	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NONPHYSIC. ANESTHET.	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		19	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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
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	985						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		189,714		189,714			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		152,801		152,801			50
53	Anesthesiology		6,618		6,618			53
54	Radiology-Diagnostic		46,058		46,058			54
57	CT Scan		31,760		31,760			57
58	MRI		7,311		7,311			58
60	Laboratory		42,783		42,783			60
62	Whole Blood & Packed Red Blood Cells		2,332		2,332			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		16,295		16,295			65
66	Physical Therapy		18,960		18,960			66
66.01	CARDIAC REHAB		5,162		5,162			66.01
67	Occupational Therapy		1,121		1,121			67
68	Speech Pathology		84		84			68
71	Medical Supplies Charged to Patients		5,439		5,439			71
72	Impl. Dev. Charged to Patients		215		215			72
73	Drugs Charged to Patients		9,930		9,930			73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE		346		346			76.01
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		83,620		83,620			88
90	Clinic		26,722		26,722			90
91	Emergency		40,259		40,259			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		687,530		687,530			118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		26,644		26,644			192
200	Cross Foot Adjustments	985	985		985			200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	985	715,159		715,159			202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	ADMIN & GENERAL GROSS REVENUE	PURCHASING RECEIVING AND STORES COSTED REQUIS	COMMUNICAT PHONES	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	79,159						1
2	Cap Rel Costs-Mvble Equip		157,213					2
4	Employee Benefits Department			6,502,082				4
5.01	ADMINISTRATIVE & GENERAL	2,123	8,759	335,155	38,329,001			5.01
5.02	PURCHASING RECEIVING AND STORES	695		69,911		1,345,731		5.02
5.03	COMMUNICATIONS					4,564	176	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	5,817	20,887	336,922		68,333	15	5.04
6	Maintenance & Repairs			178,963		34,261		6
7	Operation of Plant	15,804	3,238			491	10	7
8	Laundry & Linen Service							8
9	Housekeeping	908	687	197,870		27,046	1	9
10	Dietary	1,026	255	31,607		30,361	5	10
11	Cafeteria	2,383	1,338	165,937		159,398		11
12	Maintenance of Personnel							12
13	Nursing Administration	316		163,966		4,562	8	13
14	Central Services & Supply							14
15	Pharmacy	472		204,300		6,927		15
16	Medical Records & Library	1,570	3,881	234,912		1,607	16	16
17	Social Service	50		33,970		299	3	17
19	Nonphysician Anesthetists			100,472				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	12,515	23,038	967,659	1,770,073	109,695	28	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,666	34,663	237,327	4,924,085	173,437	9	50
53	Anesthesiology	56	4,060		515,234	16,323	1	53
54	Radiology-Diagnostic	1,240	18,956	255,691	4,397,199	63,013	4	54
57	CT Scan	845	14,089	19,508	4,320,402	3,904	1	57
58	MRI	529			1,668,997		1	58
60	Laboratory	1,112	12,812	497,547	7,236,179	239,146	6	60
62	Whole Blood & Packed Red Blood Cells	190			370,536	7,384		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	897	2,805	170,218	937,225	22,317	5	65
66	Physical Therapy	1,494	1,795	151,029	927,256	20,985	2	66
66.01	CARDIAC REHAB	406	632	13,880	37,391	167	2	66.01
67	Occupational Therapy			82,280	406,012	828		67
68	Speech Pathology			8,660	35,425			68
71	Medical Supplies Charged to Patients	505			785,442	41,614		71
72	Impl. Dev. Charged to Patients				106,905			72
73	Drugs Charged to Patients		139		2,021,807	216,643	2	73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE			49,018	20,156	359		76.01
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	9,647	2,102	1,496,048	2,801,132	47,104	39	88
90	Clinic	2,679	584	81,572	279,378	6,227	8	90
91	Emergency	2,382	1,658	417,660	4,768,167	31,670	10	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	75,327	156,378	6,502,082	38,329,001	1,338,665	176	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	3,832	835			7,066		192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	499,960	215,199	1,755,552	739,731	90,730	56,007	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.315896	1.368837	0.269998	0.019300	0.067421	318.221591	203
204	Cost to be allocated (Per Wkst. B, Part II)				25,399	4,390	15	204
205	Unit Cost Multiplier (Wkst. B, Part II)				0.000663	0.003262	0.085227	205

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

	COST CENTER DESCRIPTIONS	RECON-CILIATION	OTHER ADMINISTRA & GENERAL ACCUM COST	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	
		5A.04	5.04	6	7	8	9	
	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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	-1,892,488	12,614,415					5.04
6	Maintenance & Repairs		389,872	70,524				6
7	Operation of Plant		284,535	15,804	41,241			7
8	Laundry & Linen Service		112,165			80,842		8
9	Housekeeping		287,162	908	908		9,315	9
10	Dietary		86,027	1,026	1,026	472	174	10
11	Cafeteria		293,224	2,383	2,383		914	11
12	Maintenance of Personnel							12
13	Nursing Administration		224,559	316	316		85	13
14	Central Services & Supply							14
15	Pharmacy		274,442	472	472		53	15
16	Medical Records & Library		435,289	1,570	1,570		75	16
17	Social Service		44,433	50	50			17
19	Nonphysician Anesthetists		137,360					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		1,503,887	12,515	12,515	33,675	1,868	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		809,288	9,666	9,666	14,666	1,416	50
53	Anesthesiology		29,912	56	56			53
54	Radiology-Diagnostic		966,276	1,240	1,240	6,604	204	54
57	CT Scan		231,085	845	845	2,520	201	57
58	MRI		221,545	529	529	974	77	58
60	Laboratory		1,194,877	1,112	1,112		430	60
62	Whole Blood & Packed Red Blood Cells		70,614	190	190			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		272,645	897	897	335	127	65
66	Physical Therapy		246,239	1,494	1,494	4,232	175	66
66.01	CARDIAC REHAB		23,231	406	406	31	199	66.01
67	Occupational Therapy		113,280					67
68	Speech Pathology		11,682					68
71	Medical Supplies Charged to Patients		53,043	505	505			71
72	Impl. Dev. Charged to Patients		27,679					72
73	Drugs Charged to Patients		271,096					73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE		63,804					76.01
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		2,146,173	9,647			872	88
90	Clinic		140,583	2,679	2,679		434	90
91	Emergency		1,608,685	2,382	2,382	17,002	1,177	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	-1,892,488	12,574,692	66,692	41,241	80,511	8,481	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		39,723	3,832		331	834	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		1,892,488	448,363	427,698	128,993	345,434	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.150026	6.357595	10.370699	1.595619	37.083629	203
204	Cost to be allocated (Per Wkst. B, Part II)		65,555	2,138	106,209	583	10,621	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.005197	0.030316	2.575326	0.007212	1.140204	205

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

	COST CENTER DESCRIPTIONS	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	
		10	11	13	14	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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	8,831						10
11	Cafeteria		9,657					11
12	Maintenance of Personnel							12
13	Nursing Administration		204	81,208				13
14	Central Services & Supply				1,016,715			14
15	Pharmacy		208		6,927	100		15
16	Medical Records & Library		676		1,607		304	16
17	Social Service		161		299			17
19	Nonphysician Anesthetists		100					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	8,831	2,222	46,221	109,695		191	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		496	10,315	173,437		96	50
53	Anesthesiology		4		16,323			53
54	Radiology-Diagnostic		230		63,013			54
57	CT Scan		225		3,904			57
58	MRI		88					58
60	Laboratory		1,129		239,146			60
62	Whole Blood & Packed Red Blood Cells				7,384			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		325		22,317		17	65
66	Physical Therapy		251	5,228	20,985			66
66.01	CARDIAC REHAB		111		167			66.01
67	Occupational Therapy		96		828			67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients				41,614			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients				216,643	100		73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE				359			76.01
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		1,978		47,104			88
90	Clinic		218		6,227			90
91	Emergency		935	19,444	31,670			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	8,831	9,657	81,208	1,009,649	100	304	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				7,066			192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	123,302	410,972	275,369		334,328	558,406	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.962405	42.556902	3.390910		3,343.280000	1,836.861842	203
204	Cost to be allocated (Per Wkst. B, Part II)	10,249	26,178	4,653		6,284	23,505	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.160571	2.710780	0.057297		62.840000	77.319079	205

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME					
		17	19					
	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	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
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		100					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	100						30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology		100					53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
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
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE							76.01
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
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	100					118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	58,788	162,224					202
203	Unit Cost Multiplier (Wkst. B, Part I)	587.880000	1,622.240000					203
204	Cost to be allocated (Per Wkst. B, Part II)	1,115	985					204
205	Unit Cost Multiplier (Wkst. B, Part II)	11.150000	9.850000					205

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,846,091		2,846,091			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,400,733		1,400,733			50
53	Anesthesiology	197,731		197,731			53
54	Radiology-Diagnostic	1,159,876		1,159,876			54
57	CT Scan	300,939		300,939			57
58	MRI	271,786		271,786			58
60	Laboratory	1,456,735		1,456,735			60
62	Whole Blood & Packed Red Blood Cells	84,386		84,386			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	378,858		378,858			65
66	Physical Therapy	349,826		349,826			66
66.01	CARDIAC REHAB	45,661		45,661			66.01
67	Occupational Therapy	134,360		134,360			67
68	Speech Pathology	13,435		13,435			68
71	Medical Supplies Charged to Patients	69,449		69,449			71
72	Impl. Dev. Charged to Patients	31,832		31,832			72
73	Drugs Charged to Patients	646,095		646,095			73
76	OTHER ANCILLARY SERVICE COST CENTER						76
76.01	OCCUPATIONAL MEDICINE	73,376		73,376			76.01
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	2,645,997		2,645,997			88
90	Clinic	231,860		231,860			90
91	Emergency	2,066,377		2,066,377			91
92	Observation Beds (Non-Distinct Part)	116,895		116,895			92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	14,522,298		14,522,298			200
201	Less Observation Beds	116,895		116,895			201
202	Total (line 200 minus line 201)	14,405,403		14,405,403			202

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	1,687,667		1,687,667				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	887,459	4,036,626	4,924,085	0.284466			50
53	Anesthesiology	86,719	428,515	515,234	0.383769			53
54	Radiology-Diagnostic	321,853	4,075,346	4,397,199	0.263776			54
57	CT Scan	215,497	4,104,905	4,320,402	0.069655			57
58	MRI	53,672	1,615,325	1,668,997	0.162844			58
60	Laboratory	723,636	6,512,543	7,236,179	0.201313			60
62	Whole Blood & Packed Red Blood Cells	271,532	99,004	370,536	0.227740			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	539,156	398,069	937,225	0.404234			65
66	Physical Therapy	127,036	800,220	927,256	0.377270			66
66.01	CARDIAC REHAB		37,391	37,391	1.221176			66.01
67	Occupational Therapy	86,875	319,137	406,012	0.330926			67
68	Speech Pathology	28,950	6,475	35,425	0.379252			68
71	Medical Supplies Charged to Patients	723,919	61,523	785,442	0.088420			71
72	Impl. Dev. Charged to Patients		106,905	106,905	0.297760			72
73	Drugs Charged to Patients	1,347,802	674,005	2,021,807	0.319563			73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE		20,156	20,156	3.640405			76.01
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	214,656	2,586,476	2,801,132				88
90	Clinic	531	278,847	279,378	0.829915			90
91	Emergency	108,925	4,659,242	4,768,167	0.433369			91
92	Observation Beds (Non-Distinct Part)	1,000	81,406	82,406	1.418525			92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	7,426,885	30,902,116	38,329,001				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	7,426,885	30,902,116	38,329,001				202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1344** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.284466		1,869,696			531,865		50
53	Anesthesiology	0.383769		177,630			68,169		53
54	Radiology-Diagnostic	0.263776		1,122,399			296,062		54
57	CT Scan	0.069655		1,125,848			78,421		57
58	MRI	0.162844		327,886			53,394		58
60	Laboratory	0.201313		2,326,549			468,365		60
62	Whole Blood & Packed Red Blood	0.227740		25,705			5,854		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.404234		159,835			64,611		65
66	Physical Therapy	0.377270		293,021			110,548		66
66.01	CARDIAC REHAB	1.221176		28,392			34,672		66.01
67	Occupational Therapy	0.330926		90,463			29,937		67
68	Speech Pathology	0.379252		3,692			1,400		68
71	Medical Supplies Charged to Pat	0.088420		22,829			2,019		71
72	Impl. Dev. Charged to Patients	0.297760		87,407			26,026		72
73	Drugs Charged to Patients	0.319563		424,532			135,665		73
76	OTHER ANCILLARY SERVICE COST CE								76
76.01	OCCUPATIONAL MEDICINE	3.640405							76.01
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
90	Clinic	0.829915		96,707			80,259		90
91	Emergency	0.433369		1,324,388			573,949		91
92	Observation Beds (Non-Distinct	1.418525		37,402			53,056		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			9,544,381			2,614,272		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			9,544,381			2,614,272		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z344** **WORKSHEET D PART V**

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.284466							50
53	Anesthesiology	0.383769							53
54	Radiology-Diagnostic	0.263776							54
57	CT Scan	0.069655							57
58	MRI	0.162844							58
60	Laboratory	0.201313							60
62	Whole Blood & Packed Red Blood	0.227740							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.404234							65
66	Physical Therapy	0.377270							66
66.01	CARDIAC REHAB	1.221176							66.01
67	Occupational Therapy	0.330926							67
68	Speech Pathology	0.379252							68
71	Medical Supplies Charged to Pat	0.088420							71
72	Impl. Dev. Charged to Patients	0.297760							72
73	Drugs Charged to Patients	0.319563							73
76	OTHER ANCILLARY SERVICE COST CE								76
76.01	OCCUPATIONAL MEDICINE	3.640405							76.01
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
90	Clinic	0.829915							90
91	Emergency	0.433369							91
92	Observation Beds (Non-Distinct	1.418525							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[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)	189,714	34,496	155,218	2,251	68.96	304	20,964	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)	189,714		155,218	2,251		304	20,964	200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1344** **WORKSHEET D PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	152,801	4,924,085	0.031031	393,408	12,208	50
53	Anesthesiology	6,618	515,234	0.012845	36,363	467	53
54	Radiology-Diagnostic	46,058	4,397,199	0.010474	30,612	321	54
57	CT Scan	31,760	4,320,402	0.007351	29,902	220	57
58	MRI	7,311	1,668,997	0.004380	4,002	18	58
60	Laboratory	42,783	7,236,179	0.005912	84,230	498	60
62	Whole Blood & Packed Red Blood	2,332	370,536	0.006294	49,315	310	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	16,295	937,225	0.017386	56,287	979	65
66	Physical Therapy	18,960	927,256	0.020447	4,727	97	66
66.01	CARDIAC REHAB	5,162	37,391	0.138055			66.01
67	Occupational Therapy	1,121	406,012	0.002761	3,275	9	67
68	Speech Pathology	84	35,425	0.002371			68
71	Medical Supplies Charged to Pat	5,439	785,442	0.006925	70,763	490	71
72	Impl. Dev. Charged to Patients	215	106,905	0.002011			72
73	Drugs Charged to Patients	9,930	2,021,807	0.004911	180,274	885	73
76	OTHER ANCILLARY SERVICE COST CE						76
76.01	OCCUPATIONAL MEDICINE	346	20,156	0.017166			76.01
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	83,620	2,801,132	0.029852			88
90	Clinic	26,722	279,378	0.095648			90
91	Emergency	40,259	4,768,167	0.008443	77,987	658	91
92	Observation Beds (Non-Distinct	7,792	82,406	0.094556			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	505,608	36,641,334		1,021,145	17,160	200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

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

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS **WORKSHEET D PART III**

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

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,251		304		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)	2,251		304		200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1344** | **WORKSHEET D PART IV**

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

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology	162,224				162,224		53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
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
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY SERVICE COST CE							76
76.01	OCCUPATIONAL MEDICINE							76.01
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
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	162,224				162,224		200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1344** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/IID | [ ] PPS [ ] TEFRA [XX] 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	4,924,085			393,408				50
53	Anesthesiology	515,234	0.314855		36,363	11,449			53
54	Radiology-Diagnostic	4,397,199			30,612				54
57	CT Scan	4,320,402			29,902				57
58	MRI	1,668,997			4,002				58
60	Laboratory	7,236,179			84,230				60
62	Whole Blood & Packed Red Blood	370,536			49,315				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	937,225			56,287				65
66	Physical Therapy	927,256			4,727				66
66.01	CARDIAC REHAB	37,391							66.01
67	Occupational Therapy	406,012			3,275				67
68	Speech Pathology	35,425							68
71	Medical Supplies Charged to Pat	785,442			70,763				71
72	Impl. Dev. Charged to Patients	106,905							72
73	Drugs Charged to Patients	2,021,807			180,274				73
76	OTHER ANCILLARY SERVICE COST CE								76
76.01	OCCUPATIONAL MEDICINE	20,156							76.01
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	2,801,132							88
90	Clinic	279,378							90
91	Emergency	4,768,167			77,987				91
92	Observation Beds (Non-Distinct	82,406							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	36,641,334			1,021,145	11,449			200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1344** **WORKSHEET D PART V**

Check Applicable Boxes:

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.284466		1,183,311			336,612		50
53	Anesthesiology	0.383769		144,424			55,425		53
54	Radiology-Diagnostic	0.263776		1,259,050			332,107		54
57	CT Scan	0.069655		1,368,658			95,334		57
58	MRI	0.162844		698,150			113,690		58
60	Laboratory	0.201313		1,558,588			313,764		60
62	Whole Blood & Packed Red Blood	0.227740		32,111			7,313		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.404234		107,941			43,633		65
66	Physical Therapy	0.377270		198,016			74,705		66
66.01	CARDIAC REHAB	1.221176		124			151		66.01
67	Occupational Therapy	0.330926		70,000			23,165		67
68	Speech Pathology	0.379252		1,305			495		68
71	Medical Supplies Charged to Pat	0.088420		38,675			3,420		71
72	Impl. Dev. Charged to Patients	0.297760		3,362			1,001		72
73	Drugs Charged to Patients	0.319563		175,134			55,966		73
76	OTHER ANCILLARY SERVICE COST CE								76
76.01	OCCUPATIONAL MEDICINE	3.640405							76.01
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
90	Clinic	0.829915		85,798			71,205		90
91	Emergency	0.433369		1,792,697			776,899		91
92	Observation Beds (Non-Distinct	1.418525							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			8,717,344			2,304,885		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			8,717,344			2,304,885		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1344** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,753	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,251	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)	2,138	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	250	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)	250	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	1	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,521	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)	250	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)	250	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	133.47	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	144.67	20
21	Total general inpatient routine service cost (see instructions)	2,846,091	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)	133	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	145	25
26	Total swing-bed cost (see instructions)	517,508	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,328,583	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,328,583	37

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1344** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,034.46	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,573,414	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)					1,573,414	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)					742,292	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,315,706	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
	TARGET AMOUNT AND LIMIT COMPUTATION						
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise etner zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					258,615	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					258,615	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					517,230	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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1344** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					113	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,034.47	88
89	Observation bed cost (line 87 x line 88) (see instructions)					116,895	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	189,714	2,846,091	0.066658	116,895	7,792	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1344** **WORKSHEET D-1 PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,753	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,251	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)	2,138	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	250	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)	250	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	1	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	304	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	133.47	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	144.67	20
21	Total general inpatient routine service cost (see instructions)	2,846,091	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)	133	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	145	25
26	Total swing-bed cost (see instructions)	517,508	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,328,583	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,328,583	37

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1344** **WORKSHEET D-1 PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,034.46	38
39	Program general inpatient routine service cost (line 9 x line 38)	314,476	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)	314,476	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)	288,147	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	602,623	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	20,964	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	28,609	51
52	Total Program excludable cost (sum of lines 50 and 51)	49,573	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1344** **WORKSHEET D-1**
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					113	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1344** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,081,414		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.284466	327,598	93,190	50
53	Anesthesiology	0.383769	7,372	2,829	53
54	Radiology-Diagnostic	0.263776	204,108	53,839	54
57	CT Scan	0.069655	116,683	8,128	57
58	MRI	0.162844	31,070	5,060	58
60	Laboratory	0.201313	553,402	111,407	60
62	Whole Blood & Packed Red Blood Cells	0.227740	63,408	14,441	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.404234	313,357	126,670	65
66	Physical Therapy	0.377270	62,830	23,704	66
66.01	CARDIAC REHAB	1.221176			66.01
67	Occupational Therapy	0.330926	46,808	15,490	67
68	Speech Pathology	0.379252	14,710	5,579	68
71	Medical Supplies Charged to Patients	0.088420	459,088	40,593	71
72	Impl. Dev. Charged to Patients	0.297760			72
73	Drugs Charged to Patients	0.319563	747,825	238,977	73
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.01	OCCUPATIONAL MEDICINE	3.640405			76.01
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
90	Clinic	0.829915			90
91	Emergency	0.433369	2,267	982	91
92	Observation Beds (Non-Distinct Part)	1.418525	989	1,403	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,951,515	742,292	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,951,515		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z344** **WORKSHEET D-3**

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.284466			50
53	Anesthesiology	0.383769			53
54	Radiology-Diagnostic	0.263776	20,728	5,468	54
57	CT Scan	0.069655	2,029	141	57
58	MRI	0.162844			58
60	Laboratory	0.201313	85,275	17,167	60
62	Whole Blood & Packed Red Blood Cells	0.227740	4,747	1,081	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.404234	108,830	43,993	65
66	Physical Therapy	0.377270	58,134	21,932	66
66.01	CARDIAC REHAB	1.221176			66.01
67	Occupational Therapy	0.330926	31,115	10,297	67
68	Speech Pathology	0.379252	4,933	1,871	68
71	Medical Supplies Charged to Patients	0.088420	178,751	15,805	71
72	Impl. Dev. Charged to Patients	0.297760			72
73	Drugs Charged to Patients	0.319563	237,803	75,993	73
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.01	OCCUPATIONAL MEDICINE	3.640405			76.01
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
90	Clinic	0.829915			90
91	Emergency	0.433369			91
92	Observation Beds (Non-Distinct Part)	1.418525			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		732,345	193,748	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		732,345		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1344** **WORKSHEET D-3**

Check Applicable Boxes:

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		209,511		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.284466	393,408	111,911	50
53	Anesthesiology	0.383769	36,363	13,955	53
54	Radiology-Diagnostic	0.263776	30,612	8,075	54
57	CT Scan	0.069655	29,902	2,083	57
58	MRI	0.162844	4,002	652	58
60	Laboratory	0.201313	84,230	16,957	60
62	Whole Blood & Packed Red Blood Cells	0.227740	49,315	11,231	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.404234	56,287	22,753	65
66	Physical Therapy	0.377270	4,727	1,783	66
66.01	CARDIAC REHAB	1.221176			66.01
67	Occupational Therapy	0.330926	3,275	1,084	67
68	Speech Pathology	0.379252			68
71	Medical Supplies Charged to Patients	0.088420	70,763	6,257	71
72	Impl. Dev. Charged to Patients	0.297760			72
73	Drugs Charged to Patients	0.319563	180,274	57,609	73
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.01	OCCUPATIONAL MEDICINE	3.640405			76.01
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
90	Clinic	0.829915			90
91	Emergency	0.433369	77,987	33,797	91
92	Observation Beds (Non-Distinct Part)	1.418525			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,021,145	288,147	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,021,145		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1344** **WORKSHEET E PART B**

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	2,614,272			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,614,272			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	2,640,415			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	39,515			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,426,610			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)	1,174,290			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)	1,174,290			30
31	Primary payer payments	42			31
32	Subtotal (line 30 minus line 31)	1,174,248			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)	121,795			34
35	Adjusted reimbursable bad debts (see instructions)	79,167			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	99,188			36
37	Subtotal (see instructions)	1,253,415			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)	1,253,415			40
40.01	Sequestration adjustment (see instructions)	25,068			40.01
41	Interim payments	1,367,730			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-139,383			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1344** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				1,620,217		1,367,730	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)				1,620,217		1,367,730	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					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							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.

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z344** **WORKSHEET E-1 PART I**

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				585,750			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				585,750			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					6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

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

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

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

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	574	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,521	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	64	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	2,138	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	38,329,001	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,722,683	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	473,321	7
8	Calculation of the HIT incentive payment (see instructions)	462,056	8
9	Sequestration adjustment amount (see instructions)	9,241	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	452,815	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	452,815	32

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z344** **WORKSHEET E-2**

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	522,402		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)	195,685		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	500		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)	718,087		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	718,087		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	718,087		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	13,374		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)	704,713		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	704,713		19
19.01	Sequestration adjustment (see instructions)	14,094		19.01
20	Interim payments	585,750		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	104,869		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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

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

1	Inpatient services	2,315,706	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,315,706	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,338,863	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,338,863	19
20	Deductibles (exclude professional component)	346,380	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,992,483	22
23	Coinsurance	2,520	23
24	Subtotal (line 22 minus line 23)	1,989,963	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	68,197	25
26	Adjusted reimbursable bad debts (see instructions)	44,328	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	65,687	27
28	Subtotal (sum of lines 24 and 26)	2,034,291	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,034,291	30
30.01	Sequestration adjustment (see instructions)	40,686	30.01
31	Interim payments	1,620,217	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	373,388	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1344** **WORKSHEET E-3 PART VII**

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	602,623		1
2	Medical and other services		2,304,885	2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	602,623	2,304,885	4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	602,623	2,304,885	7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	1,021,145	8,717,344	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)	1,021,145	8,717,344	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	1,021,145	8,717,344	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)	602,623	2,304,885	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)	602,623	2,304,885	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)	602,623	2,304,885	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)	602,623	2,304,885	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	602,623	2,304,885	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)	602,623	2,304,885	40
41	Interim payments	602,623	2,304,885	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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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	1,968,367				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	7,718,961				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-5,151,432				6
7	Inventory	289,940				7
8	Prepaid expenses	701,611				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	5,527,447				11
	FIXED ASSETS					
12	Land	20,150				12
13	Land improvements	573,091				13
14	Accumulated depreciation	-341,579				14
15	Buildings	9,572,078				15
16	Accumulated depreciation	-4,293,611				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	735,328				19
20	Accumulated depreciation	-450,012				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	5,910,950				23
24	Accumulated depreciation	-4,747,868				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,261,695				27
28	Accumulated depreciation	-719,896				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	7,520,326				30
	OTHER ASSETS					
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30 and 35)	13,047,773				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	697,069				37
38	Salaries, wages and fees payable	690,154				38
39	Payroll taxes payable	67,474				39
40	Notes and loans payable (short term)	556,868				40
41	Deferred income	432,350				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	838,502				44
45	Total current liabilities (sum of lines 37 thru 44)	3,282,417				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	555,920				47
48	Unsecured loans					48
49	Other long term liabilities	161,505				49
50	Total long term liabilities (sum of lines 46 thru 49)	717,425				50
51	Total liabilities (sum of lines 45 and 50)	3,999,842				51
	CAPITAL ACCOUNTS					
52	General fund balance	9,047,931				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)	9,047,931				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	13,047,773				60

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		8,860,735			1
2	Net income (loss) (from Worksheet G-3, line 29)		187,196			2
3	Total (sum of line 1 and line 2)		9,047,931			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)		9,047,931			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,047,931			19

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	1,568,892		1,568,892	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	166,178		166,178	5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	1,735,070		1,735,070	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)	1,735,070		1,735,070	17
18	Ancillary services	5,614,061	31,555,579	37,169,640	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)	214,656	1,586,476	1,801,132	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES	285,293	1,037,414	1,322,707	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,849,080	34,179,469	42,028,549	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		15,915,570	29
30	Add (specify)	1,252,450		30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		1,252,450	36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		17,168,020	43

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	42,028,549	1
2	Less contractual allowances and discounts on patients' accounts	25,318,217	2
3	Net patient revenues (line 1 minus line 2)	16,710,332	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	17,168,020	4
5	Net income from service to patients (line 3 minus line 4)	-457,688	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	76,326	6
7	Income from investments	7,411	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	120,492	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		17
18	Revenue from sale of medical records and abstracts	8,205	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		22
23	Governmental appropriations		23
24	Other (OTHER GRANS, PURCH DISC, RENT INCOM)	432,450	24
25	Total other income (sum of lines 6-24)	644,884	25
26	Total (line 5 plus line 25)	187,196	26
29	Net income (or loss) for the period (line 26 minus line 28)	187,196	29

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
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
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
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
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy							67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE							76.01
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
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

COMPONENT CCN: 14-3499

WORKSHEET M-1

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

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	594,060		594,060	7,500	601,560	-80,126	521,434	1
2	Physician Assistant	203,195		203,195		203,195		203,195	2
3	Nurse Practitioner	92,176		92,176		92,176		92,176	3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	606,617		606,617		606,617		606,617	9
10	Subtotal (sum of lines 1 through 9)	1,496,048		1,496,048	7,500	1,503,548	-80,126	1,423,422	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		12,838	12,838		12,838		12,838	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		36,536	36,536		36,536		36,536	18
19	Other Health Care Costs		6,433	6,433		6,433		6,433	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		55,807	55,807		55,807		55,807	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,496,048	55,807	1,551,855	7,500	1,559,355	-80,126	1,479,229	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy		4,948	4,948		4,948		4,948	23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)		4,948	4,948		4,948		4,948	28
	FACILITY OVERHEAD								
29	Facility Costs		29,516	29,516	13,336	42,852		42,852	29
30	Administrative Costs		81,756	81,756		81,756		81,756	30
31	Total Facility Overhead (sum of lines 29 and 30)		111,272	111,272	13,336	124,608		124,608	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,496,048	172,027	1,668,075	20,836	1,688,911	-80,126	1,608,785	32

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3499** **WORKSHEET M-2**

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	2.70	11,792	4,200	11,340		1
2	Physician Assistants	0.80	2,290	2,100	1,680		2
3	Nurse Practitioners	1.90	7,270	2,100	3,990		3
4	Subtotal (sum of lines 1 through 3)	5.40	21,352		17,010	21,352	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	5.40	21,352			21,352	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)	1,479,229	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	4,948	11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,484,177	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	0.996666	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	124,608	14
15	Parent provider overhead allocated to facility (see instructions)	1,037,212	15
16	Total overhead (sum of lines 14 and 15)	1,161,820	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,161,820	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,157,946	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	2,637,175	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.

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3499** **WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	2,637,175	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	8,859	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,628,316	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	21,352	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	21,352	6
7	Adjusted cost per visit (line 3 divided by line 6)	123.09	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)	123.09	123.09	123.09	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	2,603	2,604		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	320,403	320,526		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)		640,929		16
16.01	Total program charges (see instructions)(from contractor's records)		664,228		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		38,456		16.02
16.03	Total program preventive costs (see instructions)		37,107		16.03
16.04	Total program non-preventive costs (see instructions)		435,714		16.04
16.05	Total program cost (see instructions)		472,821		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		59,180		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		113,327		19
20	Net Medicare cost excluding vaccines (see instructions)		472,821		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,446		21
22	Total reimbursable Program cost (line 20 plus line 21)		476,267		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				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)		476,267		26
26.01	Sequestration adjustment (see instructions)		9,525		26.01
27	Interim payments		496,357		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-29,615		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.

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3499** **WORKSHEET M-4**

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,423,422	1,423,422	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000022	0.001781	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	31	2,535	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	200	2,196	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	231	4,731	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,479,229	1,479,229	6
7	Total overhead (from Wkst. M-2, line 16)	1,161,820	1,161,820	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000156	0.003198	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	181	3,716	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	412	8,447	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	3	240	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	137.33	35.20	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	1	94	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	137	3,309	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		8,859	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)		3,446	16

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2015 To: 06/30/2016	Run Date: 11/22/2016 Run Time: 17:52 Version: 2016.05 (11/01/2016)

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

COMPONENT CCN: 14-3499

WORKSHEET M-5

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

				Part B mm/dd/yyyy (1)	Part B Amount (2)	
1	Total interim payments paid to provider				496,357	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)				496,357	
	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			6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)					

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.