LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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: 11/28/2017 Time: 10:47 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 07/01/2016 and ending 06/30/2017, 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)

G
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		113,447	82,371	18,784		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		38,352				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			10,594			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		151,799	92,965	18,784		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 / 2016	To: 06 / 30 / 2017	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.	3	N		23

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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

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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

		1	2	
Rural Providers				
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	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:	212,697			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)	584,372		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 / 2016 06 / 30 / 2017	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N 0	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/30/2017	Y	10/30/2017	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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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.	N	35

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

Cost Report Preparer Contact Information				
41	First name: BRENT	Last name: KOCHEL	Title: MANAGER	41
42	Employer: KEB			42
43	Phone number: 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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	49,344.00		1,411	290	2,056	1
2	HMO and other (see instructions)						148			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						625		625	5
6	Hospital Adults & Peds. Swing Bed NF								21	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	49,344.00		2,036	290	2,702	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	49,344.00		2,036	290	2,702	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					4,844	8,245	21,744	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							32	111	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								3	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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)					355	91	541	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)		116.54			355	91	541	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		21.10						26
27	Total (sum of lines 14-26)		137.64						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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3499** **WORKSHEET S-8**

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

Clinic Address and Identification:

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

Source of Federal Funds:

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

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

Facility hours of operations (1)

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

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

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

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	0.392294	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	1,868,814	5
6	Medicaid charges	9,880,123	6
7	Medicaid cost (line 1 times line 6)	3,875,913	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

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

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

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

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

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

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

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,203,158	535,536	1,738,694	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	471,992	535,536	1,007,528	21
22	Payments received from patients for amounts previously written off as charity care	50,523	49,313	99,836	22
23	Cost of charity care (line 21 minus line 22)	421,469	486,223	907,692	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	593,956	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	156,497	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	240,764	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)	353,192	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	222,822	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,130,514	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,130,514	31

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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		522,760	522,760		522,760		522,760	1
2	00200	Cap Rel Costs-Mvble Equip		524,936	524,936		524,936	-264,873	260,063	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	649	1,939,368	1,940,017	47,289	1,987,306	-567	1,986,739	4
5.01	00580	ADMINISTRATIVE & GENERAL	337,432	274,569	612,001		612,001	-8,400	603,601	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	71,813	25,770	97,583		97,583	-25,167	72,416	5.02
5.03	01160	COMMUNICATIONS		50,371	50,371		50,371		50,371	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	380,552	1,625,570	2,006,122	-47,289	1,958,833	-43,684	1,915,149	5.04
6	00600	Maintenance & Repairs	181,547	139,192	320,739		320,739		320,739	6
7	00700	Operation of Plant		148,859	148,859		148,859		148,859	7
8	00800	Laundry & Linen Service		134,432	134,432		134,432		134,432	8
9	00900	Housekeeping	210,679	34,429	245,108		245,108		245,108	9
10	01000	Dietary	192,578	203,075	395,653	-328,392	67,261		67,261	10
11	01100	Cafeteria				328,392	328,392	-121,247	207,145	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	166,301	6,800	173,101		173,101		173,101	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	208,854	31,885	240,739		240,739		240,739	15
16	01600	Medical Records & Library	276,420	71,734	348,154		348,154	-7,001	341,153	16
17	01700	Social Service				35,365	35,365		35,365	17
19	01900	Nonphysician Anesthetists		100	100	102,670	102,770	-28,748	74,022	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	1,050,846	53,303	1,104,149	-35,365	1,068,784		1,068,784	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	197,626	218,351	415,977	-14,044	401,933		401,933	50
53	05300	Anesthesiology	205,929	16,700	222,629	-102,670	119,959	-102,670	17,289	53
54	05400	Radiology-Diagnostic	261,569	468,987	730,556		730,556		730,556	54
57	05700	CT Scan		33,412	33,412		33,412		33,412	57
58	05800	MRI		169,439	169,439		169,439		169,439	58
60	06000	Laboratory	480,851	343,425	824,276		824,276	-34,577	789,699	60
62	06200	Whole Blood & Packed Red Blood Cells		49,202	49,202		49,202		49,202	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	179,167	15,777	194,944		194,944	-368	194,576	65
66	06600	Physical Therapy	160,126	11,041	171,167		171,167		171,167	66
66.01	06601	CARDIAC REHAB	38,250	1,221	39,471		39,471	-70	39,401	66.01
67	06700	Occupational Therapy	87,813	618	88,431		88,431		88,431	67
68	06800	Speech Pathology	6,362		6,362		6,362		6,362	68
71	07100	Medical Supplies Charged to Patients		24,482	24,482		24,482		24,482	71
72	07200	Impl. Dev. Charged to Patients				14,044	14,044		14,044	72
73	07300	Drugs Charged to Patients		197,830	197,830		197,830	-1,643	196,187	73
76	03020	OTHER ANCILLARY SERVICE COST CENTER								76
76.01	03950	OCCUPATIONAL MEDICINE	16,845	12,072	28,917		28,917	-4,126	24,791	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	1,523,630	181,497	1,705,127	4,578	1,709,705	-59,198	1,650,507	88
90	09000	Clinic	75,123	456,709	531,832	16,817	548,649	-448,712	99,937	90
91	09100	Emergency	430,625	1,288,575	1,719,200		1,719,200	-227,187	1,492,013	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	6,741,587	9,276,491	16,018,078	21,395	16,039,473	-1,378,238	14,661,235	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		27,297	27,297	-21,395	5,902		5,902	192
200		TOTAL (sum of lines 118-199)	6,741,587	9,303,788	16,045,375		16,045,375	-1,378,238	14,667,137	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	159,840	168,552	1
500	Total reclassifications				159,840	168,552	500
	Code Letter - A						
1	RHC UTILITY RECLASS	B	Rural Health Clinic	88		13,092	1
500	Total reclassifications					13,092	500
	Code Letter - B						
1	SALARY RECLASS	C	Clinic	90	16,817		1
500	Total reclassifications				16,817		500
	Code Letter - C						
1	SALARIES RECLASS	D	Social Service	17	35,365		1
500	Total reclassifications				35,365		500
	Code Letter - D						
1	SALARIES RECLASS	E	Employee Benefits Department	4	47,289		1
500	Total reclassifications				47,289		500
	Code Letter - E						
1	CRNA RECLASS	F	Nonphysician Anesthetists	19	102,670		1
500	Total reclassifications				102,670		500
	Code Letter - F						
1	IMPLANT DEVICE COST RECLASS	G	Impl. Dev. Charged to Patient	72		14,044	1
500	Total reclassifications					14,044	500
	Code Letter - G						
1	RHC EXPENSES	H	Rural Health Clinic	88		8,303	1
500	Total reclassifications					8,303	500
	Code Letter - H						
	GRAND TOTAL (Increases)				361,981	203,991	

(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	159,840	168,552		1
500	Total reclassifications				159,840	168,552		500
	Code letter - A							
1	RHC UTILITY RECLASS	B	Physicians' Private Offices	192		13,092		1
500	Total reclassifications					13,092		500
	Code letter - B							
1	SALARY RECLASS	C	Rural Health Clinic	88	16,817			1
500	Total reclassifications				16,817			500
	Code letter - C							
1	SALARIES RECLASS	D	Adults & Pediatrics	30	35,365			1
500	Total reclassifications				35,365			500
	Code letter - D							
1	SALARIES RECLASS	E	OTHER ADMINISTRATIVE AND GENE	5.04	47,289			1
500	Total reclassifications				47,289			500
	Code letter - E							
1	CRNA RECLASS	F	Anesthesiology	53	102,670			1
500	Total reclassifications				102,670			500
	Code letter - F							
1	IMPLANT DEVICE COST RECLASS	G	Operating Room	50		14,044		1
500	Total reclassifications					14,044		500
	Code letter - G							
1	RHC EXPENSES	H	Physicians' Private Offices	192		8,303		1
500	Total reclassifications					8,303		500
	Code letter - H							
	GRAND TOTAL (Decreases)				361,981	203,991		

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

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	20,150					20,150		1
2	Land Improvements	573,091				48,526	524,565		2
3	Buildings and Fixtures	9,572,078	431,278		431,278	851,540	9,151,816		3
4	Building Improvements								4
5	Fixed Equipment	735,328				266,853	468,475		5
6	Movable Equipment	5,910,950	163,700		163,700	3,464,757	2,609,893		6
7	HIT-designated Assets	1,261,695					1,261,695		7
8	Subtotal (sum of lines 1-7)	18,073,292	594,978		594,978	4,631,676	14,036,594		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	18,073,292	594,978		594,978	4,631,676	14,036,594		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	461,801			55,249	5,710		522,760	1
2	Cap Rel Costs-Mvble Equip	496,481		28,455				524,936	2
3	Total (sum of lines 1-2)	958,282		28,455	55,249	5,710		1,047,696	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	10,165,006		10,165,006	0.724179					1
2	Cap Rel Costs-Mvble Equ	3,871,588		3,871,588	0.275821					2
3	Total (sum of lines 1-2)	14,036,594		14,036,594	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	461,801			55,249	5,710		522,760	1
2	Cap Rel Costs-Mvble Equip	251,130		8,933				260,063	2
3	Total (sum of lines 1-2)	712,931		8,933	55,249	5,710		782,823	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	-19,402	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	-25,136	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	-704,291				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	-121,247	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-7,001	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	-245,351	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYSICIAN MALPRACTICE COSTS	A	-42,691	Emergency	91		33
33.01	PHYSICIAN MALPRACTICE COSTS	A	-69,739	Clinic	90		33.01
34	SALE OF INSTITUTIONAL MATERIALS	B	-31	PURCHASING RECEIVING AND STORES	5.02		34
34.01	340B COSTS	A	-1,643	Drugs Charged to Patients	73		34.01
35	DONATIONS EXPENSE	A	-11,118	OTHER ADMINISTRATIVE AND GENERAL	5.04		35
36	MISC REVENUE - ADMIN	A	-3,313	OTHER ADMINISTRATIVE AND GENERAL	5.04		36
37	PHYSICIAN RECURITMENT	A	-123	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	-7,194	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	-19,849	OTHER ADMINISTRATIVE AND GENERAL	5.04		43
44	CRNA BENEFITS	A	-28,748	Nonphysician Anesthetists	19		44
44.05	CRNA MALPRACTICE	A	-989	Clinic	90		44.05
45							45
46	COST OF RHC DOCS IN HOSPITAL	A	-59,198	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)		-1,378,238				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	1,160,634	184,496	976,138					1
2	90	Clinic CLINIC	377,984	377,984						2
3	60	Laboratory LABORATORY	34,577	34,577						3
4	65	Respiratory Therapy RESPIRATORY THE	368	368						4
5	66.01	CARDIAC REHAB CARDIAC REHAB	70	70						5
6	76.01	OCCUPATIONAL MEDICIN OCCUPATIONAL ME	4,126	4,126						6
7	53	Anesthesiology CRNA	102,670	102,670						7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,680,429	704,291	976,138					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							184,496	1
2	90	Clinic CLINIC							377,984	2
3	60	Laboratory LABORATORY							34,577	3
4	65	Respiratory Therapy RESPIRATORY THE							368	4
5	66.01	CARDIAC REHAB CARDIAC REHAB							70	5
6	76.01	OCCUPATIONAL MEDICIN OCCUPATIONAL ME							4,126	6
7	53	Anesthesiology CRNA							102,670	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							704,291	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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	522,760	522,760					1
2	Cap Rel Costs-Mvble Equip	260,063		260,063				2
4	Employee Benefits Department	1,986,739			1,986,739			4
5.01	ADMINISTRATIVE & GENERAL	603,601	14,027	353	100,153	718,134		5.01
5.02	PURCHASING RECEIVING AND STORES	72,416	4,590		21,315		98,321	5.02
5.03	COMMUNICATIONS	50,371						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	1,915,149	38,230	53,283	98,916		6,823	5.04
6	Maintenance & Repairs	320,739			53,885		2,430	6
7	Operation of Plant	148,859	104,368	3,751			19	7
8	Laundry & Linen Service	134,432						8
9	Housekeeping	245,108	5,996	1,379	62,532		2,832	9
10	Dietary	67,261	6,776	317	9,717		2,431	10
11	Cafeteria	207,145	15,737	1,546	47,442		12,762	11
12	Maintenance of Personnel							12
13	Nursing Administration	173,101	2,087		49,360		204	13
14	Central Services & Supply							14
15	Pharmacy	240,739	3,117		61,990		497	15
16	Medical Records & Library	341,153	10,368	1,046	82,044		301	16
17	Social Service	35,365	330		10,497		69	17
19	Nonphysician Anesthetists	74,022			61,122			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	1,068,784	82,648	15,051	301,405	35,276	3,940	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	401,933	63,834	55,739	58,657	74,642	9,521	50
53	Anesthesiology	17,289	370	6,016		7,758	861	53
54	Radiology-Diagnostic	730,556	8,262	29,877	77,636	85,584	4,929	54
57	CT Scan	33,412	5,580	53,748		80,109	1,164	57
58	MRI	169,439	3,493	175		29,950	228	58
60	Laboratory	789,699	7,449	18,100	142,721	140,078	19,235	60
62	Whole Blood & Packed Red Blood Cells	49,202	1,255			7,937	589	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	194,576	5,924	3,280	53,179	19,363	1,024	65
66	Physical Therapy	171,167	10,381	2,609	47,527	19,846	865	66
66.01	CARDIAC REHAB	39,401	2,166	739	11,353	378	55	66.01
67	Occupational Therapy	88,431			26,064	7,436	24	67
68	Speech Pathology	6,362			1,888	604		68
71	Medical Supplies Charged to Patients	24,482	3,335			15,821	1,732	71
72	Impl. Dev. Charged to Patients	14,044				1,255		72
73	Drugs Charged to Patients	196,187		4,655		33,514	16,341	73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE	24,791			5,000	275	447	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	1,650,507	68,311	3,857	447,233	57,980	4,850	88
90	Clinic	99,937	17,692	1,071	27,289	7,580	364	90
91	Emergency	1,492,013	15,731	1,939	127,814	92,748	3,153	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	14,661,235	502,057	258,531	1,986,739	718,134	97,690	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	5,902	20,703	1,532			631	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	14,667,137	522,760	260,063	1,986,739	718,134	98,321	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	50,371						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	4,797	2,117,198	2,117,198				5.04
6	Maintenance & Repairs		377,054	63,610	440,664			6
7	Operation of Plant	1,199	258,196	43,558	98,713	400,467		7
8	Laundry & Linen Service		134,432	22,679			157,111	8
9	Housekeeping	300	318,147	53,672	5,671	8,811		9
10	Dietary	1,499	88,001	14,846	6,408	9,956	1,573	10
11	Cafeteria		284,632	48,018	14,884	23,125		11
12	Maintenance of Personnel							12
13	Nursing Administration	899	225,651	38,068	1,974	3,066		13
14	Central Services & Supply							14
15	Pharmacy		306,343	51,681	2,948	4,580		15
16	Medical Records & Library	3,898	438,810	74,028	9,806	15,235		16
17	Social Service	600	46,861	7,906	312	485		17
19	Nonphysician Anesthetists		135,144	22,799				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	8,095	1,515,199	255,617	78,169	121,448	68,860	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,097	669,423	112,933	60,374	93,799	24,740	50
53	Anesthesiology	300	32,594	5,499	350	543		53
54	Radiology-Diagnostic	2,099	938,943	158,402	7,814	12,140	12,320	54
57	CT Scan	300	174,313	29,407	5,278	8,200	4,893	57
58	MRI	300	203,585	34,345	3,304	5,133	1,857	58
60	Laboratory	1,799	1,119,081	188,791	7,046	10,946		60
62	Whole Blood & Packed Red Blood Cells		58,983	9,951	1,187	1,844		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,199	278,545	46,991	5,603	8,705	341	65
66	Physical Therapy	600	252,995	42,681	9,819	15,255	8,830	66
66.01	CARDIAC REHAB	600	54,692	9,227	2,049	3,183	159	66.01
67	Occupational Therapy		121,955	20,574				67
68	Speech Pathology		8,854	1,494				68
71	Medical Supplies Charged to Patients		45,370	7,654	3,154	4,901		71
72	Impl. Dev. Charged to Patients		15,299	2,581				72
73	Drugs Charged to Patients	600	251,297	42,394				73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE		30,513	5,148				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	11,393	2,244,131	378,585	64,609			88
90	Clinic	2,099	156,032	26,323	16,733	25,997		90
91	Emergency	2,698	1,736,096	292,883	14,878	23,115	33,316	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	50,371	14,638,369	2,112,345	421,083	400,467	156,889	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		28,768	4,853	19,581		222	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	50,371	14,667,137	2,117,198	440,664	400,467	157,111	202

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	386,301						9
10	Dietary	7,903	128,687					10
11	Cafeteria	38,551		409,210				11
12	Maintenance of Personnel							12
13	Nursing Administration	2,646		8,501	279,906			13
14	Central Services & Supply							14
15	Pharmacy	3,147		8,291		376,990		15
16	Medical Records & Library	4,399		32,077			574,355	16
17	Social Service			6,784				17
19	Nonphysician Anesthetists			4,271				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	87,796	128,687	92,880	161,430		331,914	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	58,328		17,253	29,976		165,957	50
53	Anesthesiology							53
54	Radiology-Diagnostic	7,689		9,506				54
57	CT Scan	7,224		8,961				57
58	MRI	2,754		3,392				58
60	Laboratory	15,199		46,105				60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,685		13,735			76,484	65
66	Physical Therapy	8,225		11,181	19,423			66
66.01	CARDIAC REHAB	3,827		4,523				66.01
67	Occupational Therapy			4,146				67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients					376,990		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	36,513		88,358				88
90	Clinic	17,523		9,506				90
91	Emergency	47,313		39,740	69,077			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	353,722	128,687	409,210	279,906	376,990	574,355	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	32,579						192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	386,301	128,687	409,210	279,906	376,990	574,355	202

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	62,348						17
19	Nonphysician Anesthetists		162,214					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	62,348		2,904,348		2,904,348		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			1,232,783		1,232,783		50
53	Anesthesiology		162,214	201,200		201,200		53
54	Radiology-Diagnostic			1,146,814		1,146,814		54
57	CT Scan			238,276		238,276		57
58	MRI			254,370		254,370		58
60	Laboratory			1,387,168		1,387,168		60
62	Whole Blood & Packed Red Blood Cells			71,965		71,965		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			435,089		435,089		65
66	Physical Therapy			368,409		368,409		66
66.01	CARDIAC REHAB			77,660		77,660		66.01
67	Occupational Therapy			146,675		146,675		67
68	Speech Pathology			10,348		10,348		68
71	Medical Supplies Charged to Patients			61,079		61,079		71
72	Impl. Dev. Charged to Patients			17,880		17,880		72
73	Drugs Charged to Patients			670,681		670,681		73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE			35,661		35,661		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			2,812,196		2,812,196		88
90	Clinic			252,114		252,114		90
91	Emergency			2,256,418		2,256,418		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	62,348	162,214	14,581,134		14,581,134		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			86,003		86,003		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	62,348	162,214	14,667,137		14,667,137		202

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

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	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		14,027	353	14,380	14,380		5.01
5.02	PURCHASING RECEIVING AND STORES		4,590		4,590		4,590	5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL		38,230	53,283	91,513		319	5.04
6	Maintenance & Repairs						113	6
7	Operation of Plant		104,368	3,751	108,119		1	7
8	Laundry & Linen Service							8
9	Housekeeping		5,996	1,379	7,375		132	9
10	Dietary		6,776	317	7,093		113	10
11	Cafeteria		15,737	1,546	17,283		596	11
12	Maintenance of Personnel							12
13	Nursing Administration		2,087		2,087		10	13
14	Central Services & Supply							14
15	Pharmacy		3,117		3,117		23	15
16	Medical Records & Library		10,368	1,046	11,414		14	16
17	Social Service		330		330		3	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		82,648	15,051	97,699	707	184	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		63,834	55,739	119,573	1,495	444	50
53	Anesthesiology		370	6,016	6,386	155	40	53
54	Radiology-Diagnostic		8,262	29,877	38,139	1,714	230	54
57	CT Scan		5,580	53,748	59,328	1,605	54	57
58	MRI		3,493	175	3,668	600	11	58
60	Laboratory		7,449	18,100	25,549	2,800	899	60
62	Whole Blood & Packed Red Blood Cells		1,255		1,255	159	28	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		5,924	3,280	9,204	388	48	65
66	Physical Therapy		10,381	2,609	12,990	398	40	66
66.01	CARDIAC REHAB		2,166	739	2,905	8	3	66.01
67	Occupational Therapy					149	1	67
68	Speech Pathology					12		68
71	Medical Supplies Charged to Patients		3,335		3,335	317	81	71
72	Impl. Dev. Charged to Patients					25		72
73	Drugs Charged to Patients			4,655	4,655	671	763	73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE					6	21	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		68,311	3,857	72,168	1,161	226	88
90	Clinic		17,692	1,071	18,763	152	17	90
91	Emergency		15,731	1,939	17,670	1,858	147	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		502,057	258,531	760,588	14,380	4,561	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		20,703	1,532	22,235		29	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		522,760	260,063	782,823	14,380	4,590	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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

	COST CENTER DESCRIPTIONS	OTHER ADMINISTRA & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.04	6	7	8	9	10	
	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	91,832						5.04
6	Maintenance & Repairs	2,759	2,872					6
7	Operation of Plant	1,889	643	110,652				7
8	Laundry & Linen Service	984			984			8
9	Housekeeping	2,328	37	2,435		12,307		9
10	Dietary	644	42	2,751	10	252	10,905	10
11	Cafeteria	2,083	97	6,390		1,228		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,651	13	847		84		13
14	Central Services & Supply							14
15	Pharmacy	2,242	19	1,266		100		15
16	Medical Records & Library	3,211	64	4,210		140		16
17	Social Service	343	2	134				17
19	Nonphysician Anesthetists	989						19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	11,087	509	33,557	431	2,799	10,905	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,898	393	25,917	155	1,858		50
53	Anesthesiology	238	2	150				53
54	Radiology-Diagnostic	6,870	51	3,354	77	245		54
57	CT Scan	1,275	34	2,266	31	230		57
58	MRI	1,490	22	1,418	12	88		58
60	Laboratory	8,188	46	3,025		484		60
62	Whole Blood & Packed Red Blood Cells	432	8	509				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,038	37	2,405	2	149		65
66	Physical Therapy	1,851	64	4,215	55	262		66
66.01	CARDIAC REHAB	400	13	879	1	122		66.01
67	Occupational Therapy	892						67
68	Speech Pathology	65						68
71	Medical Supplies Charged to Patients	332	21	1,354				71
72	Impl. Dev. Charged to Patients	112						72
73	Drugs Charged to Patients	1,839						73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE	223						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	16,424	421			1,163		88
90	Clinic	1,142	109	7,183		558		90
91	Emergency	12,703	97	6,387	209	1,507		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	91,622	2,744	110,652	983	11,269	10,905	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	210	128		1	1,038		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	91,832	2,872	110,652	984	12,307	10,905	202

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

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	
		11	13	15	16	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	27,677						11
12	Maintenance of Personnel							12
13	Nursing Administration	575	5,267					13
14	Central Services & Supply							14
15	Pharmacy	561		7,328				15
16	Medical Records & Library	2,170			21,223			16
17	Social Service	459				1,271		17
19	Nonphysician Anesthetists	289					1,278	19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,282	3,038		12,265	1,271		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,167	564		6,132			50
53	Anesthesiology							53
54	Radiology-Diagnostic	643						54
57	CT Scan	606						57
58	MRI	229						58
60	Laboratory	3,118						60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	929			2,826			65
66	Physical Therapy	756	365					66
66.01	CARDIAC REHAB	306						66.01
67	Occupational Therapy	280						67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			7,328				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	5,976						88
90	Clinic	643						90
91	Emergency	2,688	1,300					91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	27,677	5,267	7,328	21,223	1,271		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross Foot Adjustments						1,278	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	27,677	5,267	7,328	21,223	1,271	1,278	202

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		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 SERV COST CENTERS							
30	Adults & Pediatrics	180,734		180,734				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	162,596		162,596				50
53	Anesthesiology	6,971		6,971				53
54	Radiology-Diagnostic	51,323		51,323				54
57	CT Scan	65,429		65,429				57
58	MRI	7,538		7,538				58
60	Laboratory	44,109		44,109				60
62	Whole Blood & Packed Red Blood Cells	2,391		2,391				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	18,026		18,026				65
66	Physical Therapy	20,996		20,996				66
66.01	CARDIAC REHAB	4,637		4,637				66.01
67	Occupational Therapy	1,322		1,322				67
68	Speech Pathology	77		77				68
71	Medical Supplies Charged to Patients	5,440		5,440				71
72	Impl. Dev. Charged to Patients	137		137				72
73	Drugs Charged to Patients	15,256		15,256				73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE	250		250				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	97,539		97,539				88
90	Clinic	28,567		28,567				90
91	Emergency	44,566		44,566				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	757,904		757,904				118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	23,641		23,641				192
200	Cross Foot Adjustments	1,278		1,278				200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	782,823		782,823				202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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		222,423					2
4	Employee Benefits Department			6,693,649				4
5.01	ADMINISTRATIVE & GENERAL	2,124	302	337,432	37,168,924			5.01
5.02	PURCHASING RECEIVING AND STORES	695		71,813		1,170,559		5.02
5.03	COMMUNICATIONS						168	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	5,789	45,571	333,263		81,236	16	5.04
6	Maintenance & Repairs			181,547		28,932		6
7	Operation of Plant	15,804	3,208			223	4	7
8	Laundry & Linen Service							8
9	Housekeeping	908	1,179	210,679		33,717	1	9
10	Dietary	1,026	271	32,738		28,941	5	10
11	Cafeteria	2,383	1,322	159,840		151,941		11
12	Maintenance of Personnel							12
13	Nursing Administration	316		166,301		2,427	3	13
14	Central Services & Supply							14
15	Pharmacy	472		208,854		5,919		15
16	Medical Records & Library	1,570	895	276,420		3,582	13	16
17	Social Service	50		35,365		820	2	17
19	Nonphysician Anesthetists			205,929				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	12,873	1,015,481	1,825,764	46,904	27	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,666	47,673	197,626	3,863,271	113,348	17	50
53	Anesthesiology	56	5,145		401,527	10,254	1	53
54	Radiology-Diagnostic	1,251	25,553	261,569	4,429,590	58,685	7	54
57	CT Scan	845	45,969		4,146,237	13,861	1	57
58	MRI	529	150		1,550,113	2,718	1	58
60	Laboratory	1,128	15,480	480,851	7,250,415	228,997	6	60
62	Whole Blood & Packed Red Blood Cells	190			410,774	7,014		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	897	2,805	179,167	1,002,163	12,187	4	65
66	Physical Therapy	1,572	2,231	160,126	1,027,152	10,301	2	66
66.01	CARDIAC REHAB	328	632	38,250	19,551	658	2	66.01
67	Occupational Therapy			87,813	384,842	284		67
68	Speech Pathology			6,362	31,283			68
71	Medical Supplies Charged to Patients	505			818,842	20,621		71
72	Impl. Dev. Charged to Patients				64,952			72
73	Drugs Charged to Patients		3,981		1,734,590	194,548	2	73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE			16,845	14,254	5,318		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	10,344	3,299	1,506,813	3,000,889	57,744	38	88
90	Clinic	2,679	916	91,940	392,344	4,332	7	90
91	Emergency	2,382	1,658	430,625	4,800,371	37,535	9	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	76,024	221,113	6,693,649	37,168,924	1,163,047	168	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	3,135	1,310			7,512		192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	522,760	260,063	1,986,739	718,134	98,321	50,371	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.603924	1.169227	0.296810	0.019321	0.083995	299.827381	203
204	Cost to be allocated (Per Wkst. B, Part II)				14,380	4,590		204
205	Unit Cost Multiplier (Wkst. B, Part II)				0.000387	0.003921		205

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	-2,117,198	12,549,939					5.04
6	Maintenance & Repairs		377,054	70,551				6
7	Operation of Plant		258,196	15,804	41,268			7
8	Laundry & Linen Service		134,432			77,830		8
9	Housekeeping		318,147	908	908		10,802	9
10	Dietary		88,001	1,026	1,026	779	221	10
11	Cafeteria		284,632	2,383	2,383		1,078	11
12	Maintenance of Personnel							12
13	Nursing Administration		225,651	316	316		74	13
14	Central Services & Supply							14
15	Pharmacy		306,343	472	472		88	15
16	Medical Records & Library		438,810	1,570	1,570		123	16
17	Social Service		46,861	50	50			17
19	Nonphysician Anesthetists		135,144					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		1,515,199	12,515	12,515	34,112	2,455	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		669,423	9,666	9,666	12,256	1,631	50
53	Anesthesiology		32,594	56	56			53
54	Radiology-Diagnostic		938,943	1,251	1,251	6,103	215	54
57	CT Scan		174,313	845	845	2,424	202	57
58	MRI		203,585	529	529	920	77	58
60	Laboratory		1,119,081	1,128	1,128		425	60
62	Whole Blood & Packed Red Blood Cells		58,983	190	190			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		278,545	897	897	169	131	65
66	Physical Therapy		252,995	1,572	1,572	4,374	230	66
66.01	CARDIAC REHAB		54,692	328	328	79	107	66.01
67	Occupational Therapy		121,955					67
68	Speech Pathology		8,854					68
71	Medical Supplies Charged to Patients		45,370	505	505			71
72	Impl. Dev. Charged to Patients		15,299					72
73	Drugs Charged to Patients		251,297					73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE		30,513					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		2,244,131	10,344			1,021	88
90	Clinic		156,032	2,679	2,679		490	90
91	Emergency		1,736,096	2,382	2,382	16,504	1,323	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	-2,117,198	12,521,171	67,416	41,268	77,720	9,891	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		28,768	3,135		110	911	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		2,117,198	440,664	400,467	157,111	386,301	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.168702	6.246035	9.704056	2.018643	35.761989	203
204	Cost to be allocated (Per Wkst. B, Part II)		91,832	2,872	110,652	984	12,307	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.007317	0.040708	2.681303	0.012643	1.139326	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	9,901						10
11	Cafeteria		9,772					11
12	Maintenance of Personnel							12
13	Nursing Administration		203	79,996				13
14	Central Services & Supply				843,142			14
15	Pharmacy		198		5,919	100		15
16	Medical Records & Library		766		3,582		398	16
17	Social Service		162		820			17
19	Nonphysician Anesthetists		102					19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	9,901	2,218	46,136	46,904		230	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		412	8,567	113,348		115	50
53	Anesthesiology				10,254			53
54	Radiology-Diagnostic		227		58,685			54
57	CT Scan		214		13,861			57
58	MRI		81		2,718			58
60	Laboratory		1,101		228,997			60
62	Whole Blood & Packed Red Blood Cells				7,014			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		328		12,187		53	65
66	Physical Therapy		267	5,551	10,301			66
66.01	CARDIAC REHAB		108		658			66.01
67	Occupational Therapy		99		284			67
68	Speech Pathology							68
71	Medical Supplies Charged to Patients				20,621			71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients				194,548	100		73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE				5,318			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		2,110		57,744			88
90	Clinic		227		4,332			90
91	Emergency		949	19,742	37,535			91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	9,901	9,772	79,996	835,630	100	398	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices				7,512			192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	128,687	409,210	279,906		376,990	574,355	202
203	Unit Cost Multiplier (Wkst. B, Part I)	12.997374	41.875767	3.499000		3,769.900000	1,443.103015	203
204	Cost to be allocated (Per Wkst. B, Part II)	10,905	27,677	5,267		7,328	21,223	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.101404	2.832276	0.065841		73.280000	53.324121	205

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	62,348	162,214					202
203	Unit Cost Multiplier (Wkst. B, Part I)	623.480000	1,622.140000					203
204	Cost to be allocated (Per Wkst. B, Part II)	1,271	1,278					204
205	Unit Cost Multiplier (Wkst. B, Part II)	12.710000	12.780000					205

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	2,904,348		2,904,348			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,232,783		1,232,783			50
53	Anesthesiology	201,200		201,200			53
54	Radiology-Diagnostic	1,146,814		1,146,814			54
57	CT Scan	238,276		238,276			57
58	MRI	254,370		254,370			58
60	Laboratory	1,387,168		1,387,168			60
62	Whole Blood & Packed Red Blood Cells	71,965		71,965			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	435,089		435,089			65
66	Physical Therapy	368,409		368,409			66
66.01	CARDIAC REHAB	77,660		77,660			66.01
67	Occupational Therapy	146,675		146,675			67
68	Speech Pathology	10,348		10,348			68
71	Medical Supplies Charged to Patients	61,079		61,079			71
72	Impl. Dev. Charged to Patients	17,880		17,880			72
73	Drugs Charged to Patients	670,681		670,681			73
76	OTHER ANCILLARY SERVICE COST CENTER						76
76.01	OCCUPATIONAL MEDICINE	35,661		35,661			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	2,812,196		2,812,196			88
90	Clinic	252,114		252,114			90
91	Emergency	2,256,418		2,256,418			91
92	Observation Beds (Non-Distinct Part)	115,345		115,345			92
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	14,696,479		14,696,479			200
201	Less Observation Beds	115,345		115,345			201
202	Total (line 200 minus line 201)	14,581,134		14,581,134			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	1,746,954		1,746,954				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	774,117	3,089,154	3,863,271	0.319103			50
53	Anesthesiology	81,401	320,126	401,527	0.501087			53
54	Radiology-Diagnostic	288,075	4,141,515	4,429,590	0.258898			54
57	CT Scan	296,899	3,849,338	4,146,237	0.057468			57
58	MRI	53,482	1,496,631	1,550,113	0.164098			58
60	Laboratory	731,456	6,518,959	7,250,415	0.191323			60
62	Whole Blood & Packed Red Blood Cells	319,372	91,402	410,774	0.175194			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	620,328	381,835	1,002,163	0.434150			65
66	Physical Therapy	179,187	847,965	1,027,152	0.358670			66
66.01	CARDIAC REHAB		19,551	19,551	3.972175			66.01
67	Occupational Therapy	129,345	255,497	384,842	0.381130			67
68	Speech Pathology	25,390	5,893	31,283	0.330787			68
71	Medical Supplies Charged to Patients	758,089	60,753	818,842	0.074592			71
72	Impl. Dev. Charged to Patients		64,952	64,952	0.275280			72
73	Drugs Charged to Patients	1,191,874	542,716	1,734,590	0.386651			73
76	OTHER ANCILLARY SERVICE COST CENTER							76
76.01	OCCUPATIONAL MEDICINE		14,254	14,254	2.501824			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	194,307	2,806,582	3,000,889				88
90	Clinic		392,344	392,344	0.642584			90
91	Emergency	2,618	4,797,753	4,800,371	0.470051			91
92	Observation Beds (Non-Distinct Part)		78,810	78,810	1.463583			92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	7,392,894	29,776,030	37,168,924				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	7,392,894	29,776,030	37,168,924				202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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
[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	0.319103		1,340,683			427,816		50
53	Anesthesiology	0.501087		128,188			64,233		53
54	Radiology-Diagnostic	0.258898		1,093,003			282,976		54
57	CT Scan	0.057468		1,176,543			67,614		57
58	MRI	0.164098		417,478			68,507		58
60	Laboratory	0.191323		2,316,674			443,233		60
62	Whole Blood & Packed Red Blood	0.175194		16,235			2,844		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.434150		151,216			65,650		65
66	Physical Therapy	0.358670		338,071			121,256		66
66.01	CARDIAC REHAB	3.972175		9,310			36,981		66.01
67	Occupational Therapy	0.381130		88,454			33,712		67
68	Speech Pathology	0.330787		1,540			509		68
71	Medical Supplies Charged to Pat	0.074592		20,485			1,528		71
72	Impl. Dev. Charged to Patients	0.275280		43,772			12,050		72
73	Drugs Charged to Patients	0.386651		367,327			142,027		73
76	OTHER ANCILLARY SERVICE COST CE								76
76.01	OCCUPATIONAL MEDICINE	2.501824							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	0.642584		85,993			55,258		90
91	Emergency	0.470051		1,348,857			634,032		91
92	Observation Beds (Non-Distinct	1.463583		28,153			41,204		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			8,971,982			2,501,430		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			8,971,982			2,501,430		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	0.319103							50
53	Anesthesiology	0.501087							53
54	Radiology-Diagnostic	0.258898							54
57	CT Scan	0.057468							57
58	MRI	0.164098							58
60	Laboratory	0.191323							60
62	Whole Blood & Packed Red Blood	0.175194							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.434150							65
66	Physical Therapy	0.358670							66
66.01	CARDIAC REHAB	3.972175							66.01
67	Occupational Therapy	0.381130							67
68	Speech Pathology	0.330787							68
71	Medical Supplies Charged to Pat	0.074592							71
72	Impl. Dev. Charged to Patients	0.275280							72
73	Drugs Charged to Patients	0.386651							73
76	OTHER ANCILLARY SERVICE COST CE								76
76.01	OCCUPATIONAL MEDICINE	2.501824							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	0.642584							90
91	Emergency	0.470051							91
92	Observation Beds (Non-Distinct	1.463583							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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	180,734	40,606	140,128	2,167	64.66	290	18,751	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)	180,734		140,128	2,167		290	18,751	200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	162,596	3,863,271	0.042088			50
53	Anesthesiology	6,971	401,527	0.017361			53
54	Radiology-Diagnostic	51,323	4,429,590	0.011586			54
57	CT Scan	65,429	4,146,237	0.015780			57
58	MRI	7,538	1,550,113	0.004863			58
60	Laboratory	44,109	7,250,415	0.006084			60
62	Whole Blood & Packed Red Blood	2,391	410,774	0.005821			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	18,026	1,002,163	0.017987			65
66	Physical Therapy	20,996	1,027,152	0.020441			66
66.01	CARDIAC REHAB	4,637	19,551	0.237175			66.01
67	Occupational Therapy	1,322	384,842	0.003435			67
68	Speech Pathology	77	31,283	0.002461			68
71	Medical Supplies Charged to Pat	5,440	818,842	0.006644			71
72	Impl. Dev. Charged to Patients	137	64,952	0.002109			72
73	Drugs Charged to Patients	15,256	1,734,590	0.008795			73
76	OTHER ANCILLARY SERVICE COST CE						76
76.01	OCCUPATIONAL MEDICINE	250	14,254	0.017539			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	97,539	3,000,889	0.032503			88
90	Clinic	28,567	392,344	0.072811			90
91	Emergency	44,566	4,800,371	0.009284			91
92	Observation Beds (Non-Distinct	7,178	78,810	0.091080			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	584,348	35,421,970				200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	2,167		290		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)	2,167		290		200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology	162,214				162,214		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)	162,214				162,214		200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [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	3,863,271							50
53	Anesthesiology	401,527	0.403993						53
54	Radiology-Diagnostic	4,429,590							54
57	CT Scan	4,146,237							57
58	MRI	1,550,113							58
60	Laboratory	7,250,415							60
62	Whole Blood & Packed Red Blood	410,774							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	1,002,163							65
66	Physical Therapy	1,027,152							66
66.01	CARDIAC REHAB	19,551							66.01
67	Occupational Therapy	384,842							67
68	Speech Pathology	31,283							68
71	Medical Supplies Charged to Pat	818,842							71
72	Impl. Dev. Charged to Patients	64,952							72
73	Drugs Charged to Patients	1,734,590							73
76	OTHER ANCILLARY SERVICE COST CE								76
76.01	OCCUPATIONAL MEDICINE	14,254							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	3,000,889							88
90	Clinic	392,344							90
91	Emergency	4,800,371							91
92	Observation Beds (Non-Distinct	78,810							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	35,421,970							200

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	0.319103							50
53	Anesthesiology	0.501087							53
54	Radiology-Diagnostic	0.258898							54
57	CT Scan	0.057468							57
58	MRI	0.164098							58
60	Laboratory	0.191323							60
62	Whole Blood & Packed Red Blood	0.175194							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.434150							65
66	Physical Therapy	0.358670							66
66.01	CARDIAC REHAB	3.972175							66.01
67	Occupational Therapy	0.381130							67
68	Speech Pathology	0.330787							68
71	Medical Supplies Charged to Pat	0.074592							71
72	Impl. Dev. Charged to Patients	0.275280							72
73	Drugs Charged to Patients	0.386651							73
76	OTHER ANCILLARY SERVICE COST CE								76
76.01	OCCUPATIONAL MEDICINE	2.501824							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	0.642584							90
91	Emergency	0.470051							91
92	Observation Beds (Non-Distinct	1.463583							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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	2,813	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,167	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)	2,056	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	312	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)	313	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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)	11	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,411	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)	312	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)	313	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16
	SWING-BED ADJUSTMENT		
17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	144.67	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	2,904,348	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,447	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,623	25
26	Total swing-bed cost (see instructions)	652,533	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,251,815	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)	2,251,815	37

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,039.14	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,466,227	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)	1,466,227	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)	765,769	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,231,996	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		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)	324,212	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	325,251	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	649,463	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					111	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,039.14	88
89	Observation bed cost (line 87 x line 88) (see instructions)					115,345	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	180,734	2,904,348	0.062229	115,345	7,178	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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	2,813	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,167	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)	2,056	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	312	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)	313	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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)	11	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	290	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	144.67	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	147.52	20
21	Total general inpatient routine service cost (see instructions)	2,904,348	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,447	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,623	25
26	Total swing-bed cost (see instructions)	652,533	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,251,815	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)	2,251,815	37

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,039.14	38
39	Program general inpatient routine service cost (line 9 x line 38)					301,351	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)					301,351	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)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					301,351	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					18,751	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)					18,751	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

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)					111	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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,055,187		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.319103	357,188	113,980	50
53	Anesthesiology	0.501087	13,141	6,585	53
54	Radiology-Diagnostic	0.258898	183,007	47,380	54
57	CT Scan	0.057468	115,186	6,620	57
58	MRI	0.164098	49,241	8,080	58
60	Laboratory	0.191323	526,506	100,733	60
62	Whole Blood & Packed Red Blood Cells	0.175194	87,564	15,341	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.434150	327,090	142,006	65
66	Physical Therapy	0.358670	70,551	25,305	66
66.01	CARDIAC REHAB	3.972175			66.01
67	Occupational Therapy	0.381130	56,857	21,670	67
68	Speech Pathology	0.330787	15,458	5,113	68
71	Medical Supplies Charged to Patients	0.074592	463,415	34,567	71
72	Impl. Dev. Charged to Patients	0.275280			72
73	Drugs Charged to Patients	0.386651	614,581	237,628	73
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.01	OCCUPATIONAL MEDICINE	2.501824			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	0.642584			90
91	Emergency	0.470051	1,618	761	91
92	Observation Beds (Non-Distinct Part)	1.463583			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,881,403	765,769	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,881,403		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	0.319103	14,935	4,766	50
53	Anesthesiology	0.501087	468	235	53
54	Radiology-Diagnostic	0.258898	19,721	5,106	54
57	CT Scan	0.057468			57
58	MRI	0.164098			58
60	Laboratory	0.191323	106,282	20,334	60
62	Whole Blood & Packed Red Blood Cells	0.175194	9,385	1,644	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.434150	137,227	59,577	65
66	Physical Therapy	0.358670	91,720	32,897	66
66.01	CARDIAC REHAB	3.972175			66.01
67	Occupational Therapy	0.381130	58,087	22,139	67
68	Speech Pathology	0.330787	5,570	1,842	68
71	Medical Supplies Charged to Patients	0.074592	174,413	13,010	71
72	Impl. Dev. Charged to Patients	0.275280			72
73	Drugs Charged to Patients	0.386651	282,586	109,262	73
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.01	OCCUPATIONAL MEDICINE	2.501824			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	0.642584			90
91	Emergency	0.470051			91
92	Observation Beds (Non-Distinct Part)	1.463583			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		900,394	270,812	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		900,394		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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
[ ] Title XVIII, Part A	[ ] IPF	[ ] SNF	[ ] Swing Bed NF	[ ] TEFRA
[XX] 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	0.319103			50
53	Anesthesiology	0.501087			53
54	Radiology-Diagnostic	0.258898			54
57	CT Scan	0.057468			57
58	MRI	0.164098			58
60	Laboratory	0.191323			60
62	Whole Blood & Packed Red Blood Cells	0.175194			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.434150			65
66	Physical Therapy	0.358670			66
66.01	CARDIAC REHAB	3.972175			66.01
67	Occupational Therapy	0.381130			67
68	Speech Pathology	0.330787			68
71	Medical Supplies Charged to Patients	0.074592			71
72	Impl. Dev. Charged to Patients	0.275280			72
73	Drugs Charged to Patients	0.386651			73
76	OTHER ANCILLARY SERVICE COST CENTER				76
76.01	OCCUPATIONAL MEDICINE	2.501824			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	0.642584			90
91	Emergency	0.470051			91
92	Observation Beds (Non-Distinct Part)	1.463583			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus 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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	2,501,430			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)	2,501,430			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)	2,526,444			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)	32,399			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,311,431			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)	1,182,614			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)	1,182,614			30
31	Primary payer payments	83			31
32	Subtotal (line 30 minus line 31)	1,182,531			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)	174,055			34
35	Adjusted reimbursable bad debts (see instructions)	113,136			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	126,726			36
37	Subtotal (see instructions)	1,295,667			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)	1,295,667			40
40.01	Sequestration adjustment (see instructions)	25,913			40.01
41	Interim payments	1,187,383			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	82,371			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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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				1,637,465		1,187,383	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	01/24/2017	161,800			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		161,800			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)				1,799,265		1,187,383	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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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				774,901			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	01/23/2017	80,300			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		80,300			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)				855,201			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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	541	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,411	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	148	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	2,056	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	37,168,924	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	1,738,694	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	584,372	7
8	Calculation of the HIT incentive payment (see instructions)	581,742	8
9	Sequestration adjustment amount (see instructions)	11,635	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	570,107	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	551,323	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	18,784	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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	655,958		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)	273,520		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	625		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)	929,478		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	929,478		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	929,478		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	17,689		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)	911,789		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)	911,789		19
19.01	Sequestration adjustment (see instructions)	18,236		19.01
20	Interim payments	855,201		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	38,352		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	2,231,996	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,231,996	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,254,316	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)	2,254,316	19
20	Deductibles (exclude professional component)	344,642	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,909,674	22
23	Coinsurance	1,288	23
24	Subtotal (line 22 minus line 23)	1,908,386	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	66,709	25
26	Adjusted reimbursable bad debts (see instructions)	43,361	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	60,489	27
28	Subtotal (sum of lines 24 and 26)	1,951,747	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,951,747	30
30.01	Sequestration adjustment (see instructions)	39,035	30.01
31	Interim payments	1,799,265	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	113,447	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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	301,351		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	301,351		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	301,351		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahrge basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	301,351		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)	301,351		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)	301,351		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)	301,351		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	301,351		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)	301,351		40
41	Interim payments	301,351		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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	2,194,721				1
2	Temporary investments	185,560				2
3	Notes receivable					3
4	Accounts receivable	10,715,845				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-7,201,716				6
7	Inventory	299,467				7
8	Prepaid expenses	196,576				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	6,390,453				11
	FIXED ASSETS					
12	Land	20,150				12
13	Land improvements	524,565				13
14	Accumulated depreciation	-328,008				14
15	Buildings	9,182,983				15
16	Accumulated depreciation	-3,897,675				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	468,476				19
20	Accumulated depreciation	-212,042				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	2,609,893				23
24	Accumulated depreciation	-1,965,524				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,261,695				27
28	Accumulated depreciation	-936,313				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	6,728,200				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)	13,118,653				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	564,746				37
38	Salaries, wages and fees payable	705,996				38
39	Payroll taxes payable	195,308				39
40	Notes and loans payable (short term)	556,868				40
41	Deferred income	212,612				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,671,918				44
45	Total current liabilities (sum of lines 37 thru 44)	3,907,448				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	232,965				47
48	Unsecured loans					48
49	Other long term liabilities	104,488				49
50	Total long term liabilities (sum of lines 46 thru 49)	337,453				50
51	Total liabilities (sum of lines 45 and 50)	4,244,901				51
	CAPITAL ACCOUNTS					
52	General fund balance	8,873,752				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)	8,873,752				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	13,118,653				60

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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		9,346,863			1
2	Net income (loss) (from Worksheet G-3, line 29)		-473,111			2
3	Total (sum of line 1 and line 2)		8,873,752			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)		8,873,752			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)		8,873,752			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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	1,588,415		1,588,415	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	216,658		216,658	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)	1,805,073		1,805,073	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)	1,805,073		1,805,073	17
18	Ancillary services	5,496,935	28,695,456	34,192,391	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)	194,307	2,890,359	3,084,666	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	220,806	937,452	1,158,258	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,717,121	32,523,267	40,240,388	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		16,045,375	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		16,045,375	43

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	40,240,388	1
2	Less contractual allowances and discounts on patients' accounts	25,135,676	2
3	Net patient revenues (line 1 minus line 2)	15,104,712	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	16,045,375	4
5	Net income from service to patients (line 3 minus line 4)	-940,663	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	1,495	6
7	Income from investments	19,402	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	121,247	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	7,032	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)	318,376	24
25	Total other income (sum of lines 6-24)	467,552	25
26	Total (line 5 plus line 25)	-473,111	26
29	Net income (or loss) for the period (line 26 minus line 28)	-473,111	29

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	464,893		464,893		464,893	-59,198	405,695	1
2	Physician Assistant	326,644		326,644		326,644		326,644	2
3	Nurse Practitioner	121,490		121,490	-16,817	104,673		104,673	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	610,603		610,603		610,603		610,603	9
10	Subtotal (sum of lines 1 through 9)	1,523,630		1,523,630	-16,817	1,506,813	-59,198	1,447,615	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		14,730	14,730		14,730		14,730	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		32,127	32,127		32,127		32,127	18
19	Other Health Care Costs		14,671	14,671		14,671		14,671	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		61,528	61,528		61,528		61,528	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,523,630	61,528	1,585,158	-16,817	1,568,341	-59,198	1,509,143	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy		7,860	7,860		7,860		7,860	23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)		7,860	7,860		7,860		7,860	28
	FACILITY OVERHEAD								
29	Facility Costs		29,413	29,413	13,872	43,285		43,285	29
30	Administrative Costs		82,696	82,696	7,523	90,219		90,219	30
31	Total Facility Overhead (sum of lines 29 and 30)		112,109	112,109	21,395	133,504		133,504	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,523,630	181,497	1,705,127	4,578	1,709,705	-59,198	1,650,507	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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	1.90	9,043	4,200	7,980		1
2	Physician Assistants	0.90	2,291	2,100	1,890		2
3	Nurse Practitioners	2.90	10,410	2,100	6,090		3
4	Subtotal (sum of lines 1 through 3)	5.70	21,744		15,960	21,744	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)	5.70	21,744			21,744	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)	1,509,143	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	7,860	11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,517,003	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	0.994819	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	133,504	14
15	Parent provider overhead allocated to facility (see instructions)	1,161,689	15
16	Total overhead (sum of lines 14 and 15)	1,295,193	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,295,193	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,288,483	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	2,797,626	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.

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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)	2,797,626	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	14,264	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,783,362	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	21,744	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	21,744	6
7	Adjusted cost per visit (line 3 divided by line 6)	128.01	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)	128.01	128.01	128.01	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	2,422	2,422		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	310,040	310,040		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)		620,080		16
16.01	Total program charges (see instructions)(from contractor's records)		691,577		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		44,094		16.02
16.03	Total program preventive costs (see instructions)		39,536		16.03
16.04	Total program non-preventive costs (see instructions)		414,185		16.04
16.05	Total program cost (see instructions)		453,721		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		62,813		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		116,934		19
20	Net Medicare cost excluding vaccines (see instructions)		453,721		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,852		21
22	Total reimbursable Program cost (line 20 plus line 21)		460,573		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)		460,573		26
26.01	Sequestration adjustment (see instructions)		9,211		26.01
27	Interim payments		440,768		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		10,594		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: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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)	1,447,615	1,447,615	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000028	0.002075	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	41	3,004	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	73	4,576	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	114	7,580	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,509,143	1,509,143	6
7	Total overhead (from Wkst. M-2, line 16)	1,288,483	1,288,483	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000076	0.005023	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	98	6,472	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	212	14,052	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	4	296	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	53.00	47.47	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	3	141	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	159	6,693	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)		14,264	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)		6,852	16

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2016 To: 06/30/2017	Run Date: 11/28/2017 Run Time: 10:47 Version: 2017.10 (11/19/2017)

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	
	DESCRIPTION					
1	Total interim payments paid to provider				440,768	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)				440,768	
	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.