KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

PART I - COST REPORT STATUS

Provider use only	1. [X] Electronically filed cost report Date: 11/26/2018 Time: 15:27 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by LAWRENCE COUNTY MEMORIAL HOSPITAL (14-1344) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 07/01/2017 and ending 06/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

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		458,788	378,673	1	34	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		210,182				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			15,686			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		668,970	394,359	1	34	200

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 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 / 2017	To: 06 / 30 / 2018	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)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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

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

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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.		N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.		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:	210,974			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

Transplant Center Information

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

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

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

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143

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

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

		Title XVIII				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	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)	1			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07 / 01 / 2017	06 / 30 / 2018	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	10/01/2018	Y	10/01/2018	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Reoprt data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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: MARK	Last name: DALLAS	Title: PARTNER	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: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	38,424.00		1,116	48	1,601	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						476		522	5
6	Hospital Adults & Peds. Swing Bed NF								25	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	38,424.00		1,592	48	2,148	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	38,424.00		1,592	48	2,148	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					4,744	8,058	21,896	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							31	103	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								16	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
33.01	LTCH site neutral days and discharges									33.01

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					364	48	481	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)		116.81			364	48	481	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		21.18						26
27	Total (sum of lines 14-26)		137.99						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	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: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

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)	0.437411	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,876,032	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	10,619,144	6
7	Medicaid cost (line 1 times line 6)	4,644,930	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.	768,898	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)	768,898	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)	1,049,986	449,994	1,499,980	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	459,275	449,994	909,269	21
22	Payments received from patients for amounts previously written off as charity care	64,508	27,646	92,154	22
23	Cost of charity care (line 21 minus line 22)	394,767	422,348	817,115	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)	723,335	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	174,106	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	267,855	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	455,480	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	292,981	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,110,096	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,878,994	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		503,123	503,123		503,123		503,123	1
2	00200	Cap Rel Costs-Mvble Equip		452,032	452,032		452,032	-173,966	278,066	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		1,908,612	1,908,612	50,031	1,958,643	-567	1,958,076	4
5.01	00580	ADMINISTRATIVE & GENERAL	336,245	292,076	628,321		628,321	-8,400	619,921	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	77,165	30,399	107,564		107,564	-22,570	84,994	5.02
5.03	01160	COMMUNICATIONS		42,722	42,722		42,722		42,722	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	446,662	1,664,276	2,110,938	-50,031	2,060,907	-61,206	1,999,701	5.04
6	00600	Maintenance & Repairs	204,000	147,436	351,436		351,436		351,436	6
7	00700	Operation of Plant		144,937	144,937		144,937		144,937	7
8	00800	Laundry & Linen Service		135,645	135,645		135,645		135,645	8
9	00900	Housekeeping	233,391	33,766	267,157		267,157		267,157	9
10	01000	Dietary	202,007	216,932	418,939	-348,854	70,085		70,085	10
11	01100	Cafeteria				348,854	348,854	-118,025	230,829	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	184,182	5,306	189,488		189,488		189,488	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	214,000	85,168	299,168		299,168		299,168	15
16	01600	Medical Records & Library	275,898	46,427	322,325		322,325	-3,759	318,566	16
17	01700	Social Service				42,828	42,828		42,828	17
19	01900	Nonphysician Anesthetists				212,667	212,667		212,667	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	1,066,611	48,665	1,115,276	-42,828	1,072,448		1,072,448	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	217,563	193,736	411,299	-13,616	397,683		397,683	50
53	05300	Anesthesiology	212,667	21,113	233,780	-212,667	21,113		21,113	53
54	05400	Radiology-Diagnostic	286,703	440,846	727,549		727,549		727,549	54
57	05700	CT Scan		101,704	101,704		101,704		101,704	57
58	05800	MRI		170,736	170,736		170,736		170,736	58
60	06000	Laboratory	499,521	317,197	816,718		816,718	-28,996	787,722	60
62	06200	Whole Blood & Packed Red Blood Cells		47,944	47,944		47,944		47,944	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	184,043	17,938	201,981		201,981	-246	201,735	65
66	06600	Physical Therapy	175,389	18,664	194,053		194,053		194,053	66
66.01	06601	CARDIAC REHAB								66.01
67	06700	Occupational Therapy	91,021	622	91,643		91,643		91,643	67
68	06800	Speech Pathology	9,849	2,858	12,707		12,707		12,707	68
71	07100	Medical Supplies Charged to Patients		20,995	20,995		20,995		20,995	71
72	07200	Impl. Dev. Charged to Patients				13,616	13,616		13,616	72
73	07300	Drugs Charged to Patients		254,260	254,260		254,260	-79,028	175,232	73
76	03020	OTHER ANCILLARY SERVICE COST CENTER								76
76.01	03950	OCCUPATIONAL MEDICINE		2,185	2,185		2,185	-2,185		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	1,557,417	157,937	1,715,354	-1,066	1,714,288	-33,094	1,681,194	88
90	09000	Clinic	70,150	444,320	514,470	18,823	533,293	-423,915	109,378	90
91	09100	Emergency	464,751	1,314,381	1,779,132		1,779,132	-119,931	1,659,201	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	7,009,235	9,284,958	16,294,193	17,757	16,311,950	-1,075,888	15,236,062	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		25,308	25,308	-17,757	7,551		7,551	192
200		TOTAL (sum of lines 118-199)	7,009,235	9,310,266	16,319,501		16,319,501	-1,075,888	15,243,613	200

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	173,967	174,887	1
500	Total reclassifications				173,967	174,887	500
	Code Letter - A						
1	RHC UTILITY RECLASS	B	Rural Health Clinic	88		17,757	1
500	Total reclassifications					17,757	500
	Code Letter - B						
1	SALARY RECLASS	C	Clinic	90	18,823		1
500	Total reclassifications				18,823		500
	Code Letter - C						
1	SALARIES RECLASS	D	Social Service	17	42,828		1
500	Total reclassifications				42,828		500
	Code Letter - D						
1	SALARIES RECLASS	E	Employee Benefits Department	4	50,031		1
500	Total reclassifications				50,031		500
	Code Letter - E						
1	CRNA RECLASS	F	Nonphysician Anesthetists	19	212,667		1
500	Total reclassifications				212,667		500
	Code Letter - F						
1	IMPLANT DEVICE COST RECLASS	G	Impl. Dev. Charged to Patient	72		13,616	1
500	Total reclassifications					13,616	500
	Code Letter - G						
	GRAND TOTAL (Increases)				498,316	206,260	

(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.

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	173,967	174,887		1
500	Total reclassifications				173,967	174,887		500
	Code letter - A							
1	RHC UTILITY RECLASS	B	Physicians' Private Offices	192		17,757		1
500	Total reclassifications					17,757		500
	Code letter - B							
1	SALARY RECLASS	C	Rural Health Clinic	88	18,823			1
500	Total reclassifications				18,823			500
	Code letter - C							
1	SALARIES RECLASS	D	Adults & Pediatrics	30	42,828			1
500	Total reclassifications				42,828			500
	Code letter - D							
1	SALARIES RECLASS	E	OTHER ADMINISTRATIVE AND GENE	5.04	50,031			1
500	Total reclassifications				50,031			500
	Code letter - E							
1	CRNA RECLASS	F	Anesthesiology	53	212,667			1
500	Total reclassifications				212,667			500
	Code letter - F							
1	IMPLANT DEVICE COST RECLASS	G	Operating Room	50		13,616		1
500	Total reclassifications					13,616		500
	Code letter - G							
	GRAND TOTAL (Decreases)				498,316	206,260		

(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	524,565	5,474		5,474		530,039		2
3	Buildings and Fixtures	9,151,816	70,284		70,284		9,222,100		3
4	Building Improvements								4
5	Fixed Equipment	468,475	43,535		43,535		512,010		5
6	Movable Equipment	2,609,893	279,102		279,102	57,312	2,831,683		6
7	HIT-designated Assets	1,261,695					1,261,695		7
8	Subtotal (sum of lines 1-7)	14,036,594	398,395		398,395	57,312	14,377,677		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	14,036,594	398,395		398,395	57,312	14,377,677		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	446,466			50,980	5,677		503,123	1
2	Cap Rel Costs-Mvble Equip	436,234		15,798				452,032	2
3	Total (sum of lines 1-2)	882,700		15,798	50,980	5,677		955,155	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	10,284,299		10,284,299	0.715296					1
2	Cap Rel Costs-Mvble Equ	4,093,378		4,093,378	0.284704					2
3	Total (sum of lines 1-2)	14,377,677		14,377,677	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	446,466			50,980	5,677		503,123	1
2	Cap Rel Costs-Mvble Equip	278,186		-120				278,066	2
3	Total (sum of lines 1-2)	724,652		-120	50,980	5,677		781,189	3

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

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)	B	-15,798	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	-22,539	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	-525,974				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	-118,025	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-3,759	Medical Records & Library	16		16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-158,048	Cap Rel Costs-Mvble Equip	2	9	32
33	PHYSICIAN MALPRACTICE COSTS	A	-12,378	Emergency	91		33
33.01	PHYSICIAN MALPRACTICE COSTS	A	-69,324	Clinic	90		33.01
34	SALE OF INSTITUTIONAL MATERIALS	B	-31	PURCHASING RECEIVING AND STORES	5.02		34
34.01	340B COSTS	A	-79,028	Drugs Charged to Patients	73		34.01
35	DONATIONS EXPENSE	A	-4,295	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	-23,502	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	-20,815	OTHER ADMINISTRATIVE AND GENERAL	5.04		43
44	OCCUPATIONAL MED	A	-691	OCCUPATIONAL MEDICINE	76.01		44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-1,075,888				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.

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

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

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								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:

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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	1,213,588	107,553	976,138					1
2	90	Clinic CLINIC	354,591	354,591						2
3	60	Laboratory LABORATORY	28,996	28,996						3
4	65	Respiratory Therapy RESPIRATORY THE	246	246						4
5	66.01	CARDIAC REHAB CARDIAC REHAB								5
6	76.01	OCCUPATIONAL MEDICIN OCCUPATIONAL ME	1,494	1,494						6
7	88	Rural Health Clinic RURAL HEALTH CI	378,031	33,094	344,937					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	1,976,946	525,974	1,321,075					200

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

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	91	Emergency EMERGENCY							107,553	1
2	90	Clinic CLINIC							354,591	2
3	60	Laboratory LABORATORY							28,996	3
4	65	Respiratory Therapy RESPIRATORY THE							246	4
5	66.01	CARDIAC REHAB CARDIAC REHAB								5
6	76.01	OCCUPATIONAL MEDICIN OCCUPATIONAL ME							1,494	6
7	88	Rural Health Clinic RURAL HEALTH CI							33,094	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							525,974	200

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

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	Overtime hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						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

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	503,123	503,123					1
2	Cap Rel Costs-Mvble Equip	278,066		278,066				2
4	Employee Benefits Department	1,958,076			1,958,076			4
5.01	ADMINISTRATIVE & GENERAL	619,921	13,500		94,608	728,029		5.01
5.02	PURCHASING RECEIVING AND STORES	84,994	4,417		21,712		111,123	5.02
5.03	COMMUNICATIONS	42,722						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	1,999,701	36,794	46,148	111,598		7,380	5.04
6	Maintenance & Repairs	351,436			57,398		3,030	6
7	Operation of Plant	144,937	100,447	3,200			21	7
8	Laundry & Linen Service	135,645						8
9	Housekeeping	267,157	5,771	1,179	65,668		3,221	9
10	Dietary	70,085	6,521	271	48,948		18,223	10
11	Cafeteria	230,829	15,146	1,321	7,889			11
12	Maintenance of Personnel							12
13	Nursing Administration	189,488	2,008		51,822		120	13
14	Central Services & Supply							14
15	Pharmacy	299,168	3,000		60,212		6,088	15
16	Medical Records & Library	318,566	9,979	895	77,628		190	16
17	Social Service	42,828	318		12,050		24	17
19	Nonphysician Anesthetists	212,667			59,837			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	1,072,448	79,544	13,276	288,057	31,318	3,788	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	397,683	61,436	86,792	61,215	72,301	8,124	50
53	Anesthesiology	21,113	356	15,331		13,957	1,479	53
54	Radiology-Diagnostic	727,549	7,951	28,103	80,668	84,981	5,180	54
57	CT Scan	101,704	5,371	45,595		79,551	1,058	57
58	MRI	170,736	3,362			29,421	190	58
60	Laboratory	787,722	7,169	15,480	140,548	146,964	19,659	60
62	Whole Blood & Packed Red Blood Cells	47,944	1,208			7,604	569	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	201,735	7,786	920	51,783	18,586	1,039	65
66	Physical Therapy	194,053	9,991	2,435	49,348	23,153	1,654	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	91,643			25,610	8,516	32	67
68	Speech Pathology	12,707			2,771	368	273	68
71	Medical Supplies Charged to Patients	20,995	3,210			13,328	1,736	71
72	Impl. Dev. Charged to Patients	13,616				1,083	135	72
73	Drugs Charged to Patients	175,232		5,758		33,650	18,697	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	1,681,194	65,745	5,982	432,907	66,001	4,321	88
90	Clinic	109,378	17,027	1,661	25,034	5,039	637	90
91	Emergency	1,659,201	15,140	1,343	130,765	92,208	3,775	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	15,236,062	483,197	275,690	1,958,076	728,029	110,643	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	7,551	19,926	2,376			480	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	15,243,613	503,123	278,066	1,958,076	728,029	111,123	202

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	42,722						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	4,890	2,206,511	2,206,511				5.04
6	Maintenance & Repairs		411,864	69,708	481,572			6
7	Operation of Plant	1,029	249,634	42,250	108,379	400,263		7
8	Laundry & Linen Service		135,645	22,958			158,603	8
9	Housekeeping	257	343,253	58,095	6,227	8,877		9
10	Dietary	1,287	145,335	24,598	7,036	10,031	2,158	10
11	Cafeteria		255,185	43,190	16,342	23,298		11
12	Maintenance of Personnel							12
13	Nursing Administration	772	244,210	41,332	2,167	3,089		13
14	Central Services & Supply							14
15	Pharmacy	515	368,983	62,450	3,237	4,615		15
16	Medical Records & Library	3,346	410,604	69,494	10,767	15,350		16
17	Social Service	257	55,477	9,389	343	489		17
19	Nonphysician Anesthetists		272,504	46,121				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	6,949	1,495,380	253,092	85,825	122,357	62,001	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,375	691,926	117,108	66,287	94,503	26,370	50
53	Anesthesiology	257	52,493	8,884	384	548		53
54	Radiology-Diagnostic	1,802	936,234	158,457	8,579	12,231	14,691	54
57	CT Scan	257	233,536	39,526	5,795	8,261	3,239	57
58	MRI	257	203,966	34,521	3,628	5,172	3,236	58
60	Laboratory	1,544	1,119,086	189,404	7,736	11,028		60
62	Whole Blood & Packed Red Blood Cells		57,325	9,702	1,303	1,858		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	515	282,364	47,790	6,151	8,770		65
66	Physical Therapy	515	281,149	47,584	10,780	15,369	12,350	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy		125,801	21,292				67
68	Speech Pathology		16,119	2,728				68
71	Medical Supplies Charged to Patients		39,269	6,646	3,463	4,937		71
72	Impl. Dev. Charged to Patients		14,834	2,511				72
73	Drugs Charged to Patients		233,337	39,492				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	9,780	2,265,930	383,500	70,937			88
90	Clinic	1,802	160,578	27,178	18,372	26,192	717	90
91	Emergency	2,316	1,904,748	322,377	16,335	23,288	33,536	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	42,722	15,213,280	2,201,377	460,073	400,263	158,298	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		30,333	5,134	21,499		305	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	42,722	15,243,613	2,206,511	481,572	400,263	158,603	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	416,452						9
10	Dietary	34,697	223,855					10
11	Cafeteria	16,333		354,348				11
12	Maintenance of Personnel							12
13	Nursing Administration	3,131		7,451	301,380			13
14	Central Services & Supply							14
15	Pharmacy	3,554		7,266		450,105		15
16	Medical Records & Library	8,505		27,394			542,114	16
17	Social Service			3,299				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	94,320	223,855	78,585	167,706		391,671	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	68,167		19,276	32,956		101,160	50
53	Anesthesiology							53
54	Radiology-Diagnostic	6,855		8,304				54
57	CT Scan	6,855		7,822				57
58	MRI	3,427		2,966				58
60	Laboratory	18,576		40,851				60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	8,928		12,048			49,283	65
66	Physical Therapy	14,344		11,492	24,551			66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy			3,707				67
68	Speech Pathology			297				68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients					450,105		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			78,513				88
90	Clinic	19,168		9,379				90
91	Emergency	62,878		35,698	76,167			91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	369,738	223,855	354,348	301,380	450,105	542,114	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	46,714						192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	416,452	223,855	354,348	301,380	450,105	542,114	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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	68,997						17
19	Nonphysician Anesthetists		318,625					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	68,997		3,043,789		3,043,789		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room			1,217,753		1,217,753		50
53	Anesthesiology		318,625	380,934		380,934		53
54	Radiology-Diagnostic			1,145,351		1,145,351		54
57	CT Scan			305,034		305,034		57
58	MRI			256,916		256,916		58
60	Laboratory			1,386,681		1,386,681		60
62	Whole Blood & Packed Red Blood Cells			70,188		70,188		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy			415,334		415,334		65
66	Physical Therapy			417,619		417,619		66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy			150,800		150,800		67
68	Speech Pathology			19,144		19,144		68
71	Medical Supplies Charged to Patients			54,315		54,315		71
72	Impl. Dev. Charged to Patients			17,345		17,345		72
73	Drugs Charged to Patients			722,934		722,934		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			2,798,880		2,798,880		88
90	Clinic			261,584		261,584		90
91	Emergency			2,475,027		2,475,027		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	68,997	318,625	15,139,628		15,139,628		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices			103,985		103,985		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	68,997	318,625	15,243,613		15,243,613		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		13,500		13,500	13,500		5.01
5.02	PURCHASING RECEIVING AND STORES		4,417		4,417		4,417	5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL		36,794	46,148	82,942		293	5.04
6	Maintenance & Repairs						120	6
7	Operation of Plant		100,447	3,200	103,647		1	7
8	Laundry & Linen Service							8
9	Housekeeping		5,771	1,179	6,950		128	9
10	Dietary		6,521	271	6,792		724	10
11	Cafeteria		15,146	1,321	16,467			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,008		2,008		5	13
14	Central Services & Supply							14
15	Pharmacy		3,000		3,000		242	15
16	Medical Records & Library		9,979	895	10,874		8	16
17	Social Service		318		318		1	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		79,544	13,276	92,820	581	151	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		61,436	86,792	148,228	1,341	323	50
53	Anesthesiology		356	15,331	15,687	259	59	53
54	Radiology-Diagnostic		7,951	28,103	36,054	1,576	206	54
57	CT Scan		5,371	45,595	50,966	1,475	42	57
58	MRI		3,362		3,362	546	8	58
60	Laboratory		7,169	15,480	22,649	2,724	781	60
62	Whole Blood & Packed Red Blood Cells		1,208		1,208	141	23	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		7,786	920	8,706	345	41	65
66	Physical Therapy		9,991	2,435	12,426	429	66	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy					158	1	67
68	Speech Pathology					7	11	68
71	Medical Supplies Charged to Patients		3,210		3,210	247	69	71
72	Impl. Dev. Charged to Patients					20	5	72
73	Drugs Charged to Patients			5,758	5,758	624	743	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		65,745	5,982	71,727	1,224	172	88
90	Clinic		17,027	1,661	18,688	93	25	90
91	Emergency		15,140	1,343	16,483	1,710	150	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		483,197	275,690	758,887	13,500	4,398	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		19,926	2,376	22,302		19	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		503,123	278,066	781,189	13,500	4,417	202

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	83,235						5.04
6	Maintenance & Repairs	2,629	2,749					6
7	Operation of Plant	1,594	620	105,862				7
8	Laundry & Linen Service	866			866			8
9	Housekeeping	2,191	36	2,348		11,653		9
10	Dietary	928	40	2,653	12	971	12,120	10
11	Cafeteria	1,629	93	6,162		457		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,559	12	817		88		13
14	Central Services & Supply							14
15	Pharmacy	2,356	18	1,220		99		15
16	Medical Records & Library	2,621	61	4,060		238		16
17	Social Service	354	2	129				17
19	Nonphysician Anesthetists	1,740						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	9,547	490	32,362	338	2,640	12,120	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,417	378	24,994	144	1,907		50
53	Anesthesiology	335	2	145				53
54	Radiology-Diagnostic	5,977	49	3,235	80	192		54
57	CT Scan	1,491	33	2,185	18	192		57
58	MRI	1,302	21	1,368	18	96		58
60	Laboratory	7,144	44	2,917		520		60
62	Whole Blood & Packed Red Blood Cells	366	7	491				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,803	35	2,319		250		65
66	Physical Therapy	1,795	62	4,065	67	401		66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	803						67
68	Speech Pathology	103						68
71	Medical Supplies Charged to Patients	251	20	1,306				71
72	Impl. Dev. Charged to Patients	95						72
73	Drugs Charged to Patients	1,490						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	14,470	405					88
90	Clinic	1,025	105	6,927	4	536		90
91	Emergency	12,160	93	6,159	183	1,759		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	83,041	2,626	105,862	864	10,346	12,120	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	194	123		2	1,307		192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	83,235	2,749	105,862	866	11,653	12,120	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	24,808						11
12	Maintenance of Personnel							12
13	Nursing Administration	522	5,011					13
14	Central Services & Supply							14
15	Pharmacy	509		7,444				15
16	Medical Records & Library	1,918			19,780			16
17	Social Service	231				1,035		17
19	Nonphysician Anesthetists						1,740	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	5,499	2,789		14,291	1,035		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,350	548		3,691			50
53	Anesthesiology							53
54	Radiology-Diagnostic	581						54
57	CT Scan	548						57
58	MRI	208						58
60	Laboratory	2,860						60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	843			1,798			65
66	Physical Therapy	805	408					66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	260						67
68	Speech Pathology	21						68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			7,444				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	5,497						88
90	Clinic	657						90
91	Emergency	2,499	1,266					91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,808	5,011	7,444	19,780	1,035		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross Foot Adjustments						1,740	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,808	5,011	7,444	19,780	1,035	1,740	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	174,663		174,663				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	187,321		187,321				50
53	Anesthesiology	16,487		16,487				53
54	Radiology-Diagnostic	47,950		47,950				54
57	CT Scan	56,950		56,950				57
58	MRI	6,929		6,929				58
60	Laboratory	39,639		39,639				60
62	Whole Blood & Packed Red Blood Cells	2,236		2,236				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	16,140		16,140				65
66	Physical Therapy	20,524		20,524				66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	1,222		1,222				67
68	Speech Pathology	142		142				68
71	Medical Supplies Charged to Patients	5,103		5,103				71
72	Impl. Dev. Charged to Patients	120		120				72
73	Drugs Charged to Patients	16,059		16,059				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	93,495		93,495				88
90	Clinic	28,060		28,060				90
91	Emergency	42,462		42,462				91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	755,502		755,502				118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	23,947		23,947				192
200	Cross Foot Adjustments	1,740		1,740				200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	781,189		781,189				202

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		278,065					2
4	Employee Benefits Department			6,959,204				4
5.01	ADMINISTRATIVE & GENERAL	2,124		336,245	34,611,919			5.01
5.02	PURCHASING RECEIVING AND STORES	695		77,165		1,161,236		5.02
5.03	COMMUNICATIONS						166	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	5,789	46,148	396,631		77,120	19	5.04
6	Maintenance & Repairs			204,000		31,668		6
7	Operation of Plant	15,804	3,200			221	4	7
8	Laundry & Linen Service							8
9	Housekeeping	908	1,179	233,391		33,663	1	9
10	Dietary	1,026	271	173,967		190,430	5	10
11	Cafeteria	2,383	1,321	28,040				11
12	Maintenance of Personnel							12
13	Nursing Administration	316		184,182		1,251	3	13
14	Central Services & Supply							14
15	Pharmacy	472		214,000		63,623	2	15
16	Medical Records & Library	1,570	895	275,898		1,983	13	16
17	Social Service	50		42,828		251	1	17
19	Nonphysician Anesthetists			212,667				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	13,276	1,023,783	1,488,928	39,587	27	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,666	86,791	217,563	3,437,334	84,895	17	50
53	Anesthesiology	56	15,331		663,521	15,454	1	53
54	Radiology-Diagnostic	1,251	28,103	286,703	4,040,181	54,130	7	54
57	CT Scan	845	45,595		3,781,999	11,056	1	57
58	MRI	529			1,398,750	1,985	1	58
60	Laboratory	1,128	15,480	499,521	6,986,861	205,432	6	60
62	Whole Blood & Packed Red Blood Cells	190			361,501	5,946		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,225	920	184,043	883,623	10,859	2	65
66	Physical Therapy	1,572	2,435	175,389	1,100,756	17,287	2	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy			91,021	404,866	337		67
68	Speech Pathology			9,849	17,493	2,858		68
71	Medical Supplies Charged to Patients	505			633,641	18,139		71
72	Impl. Dev. Charged to Patients				51,510	1,409		72
73	Drugs Charged to Patients		5,758		1,599,813	195,387		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	10,344	5,982	1,538,594	3,137,813	45,151	38	88
90	Clinic	2,679	1,661	88,973	239,557	6,658	7	90
91	Emergency	2,382	1,343	464,751	4,383,772	39,445	9	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	76,024	275,689	6,959,204	34,611,919	1,156,225	166	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	3,135	2,376			5,011		192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	503,123	278,066	1,958,076	728,029	111,123	42,722	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.355853	1.000004	0.281365	0.021034	0.095694	257.361446	203
204	Cost to be allocated (Per Wkst. B, Part II)				13,500	4,417		204
205	Unit Cost Multiplier (Wkst. B, Part II)				0.000390	0.003804		205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	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	-2,206,511	13,037,102					5.04
6	Maintenance & Repairs		411,864	70,223				6
7	Operation of Plant		249,634	15,804	40,940			7
8	Laundry & Linen Service		135,645			69,246		8
9	Housekeeping		343,253	908	908		9,842	9
10	Dietary		145,335	1,026	1,026	942	820	10
11	Cafeteria		255,185	2,383	2,383		386	11
12	Maintenance of Personnel							12
13	Nursing Administration		244,210	316	316		74	13
14	Central Services & Supply							14
15	Pharmacy		368,983	472	472		84	15
16	Medical Records & Library		410,604	1,570	1,570		201	16
17	Social Service		55,477	50	50			17
19	Nonphysician Anesthetists		272,504					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		1,495,380	12,515	12,515	27,070	2,229	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		691,926	9,666	9,666	11,513	1,611	50
53	Anesthesiology		52,493	56	56			53
54	Radiology-Diagnostic		936,234	1,251	1,251	6,414	162	54
57	CT Scan		233,536	845	845	1,414	162	57
58	MRI		203,966	529	529	1,413	81	58
60	Laboratory		1,119,086	1,128	1,128		439	60
62	Whole Blood & Packed Red Blood Cells		57,325	190	190			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		282,364	897	897		211	65
66	Physical Therapy		281,149	1,572	1,572	5,392	339	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy		125,801					67
68	Speech Pathology		16,119					68
71	Medical Supplies Charged to Patients		39,269	505	505			71
72	Impl. Dev. Charged to Patients		14,834					72
73	Drugs Charged to Patients		233,337					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		2,265,930	10,344				88
90	Clinic		160,578	2,679	2,679	313	453	90
91	Emergency		1,904,748	2,382	2,382	14,642	1,486	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	-2,206,511	13,006,769	67,088	40,940	69,113	8,738	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		30,333	3,135		133	1,104	192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		2,206,511	481,572	400,263	158,603	416,452	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.169249	6.857753	9.776820	2.290428	42.313757	203
204	Cost to be allocated (Per Wkst. B, Part II)		83,235	2,749	105,862	866	11,653	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.006384	0.039147	2.585784	0.012506	1.184007	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	DIETARY MEALS SERVED	CAFETERIA FTE'S	NURSING ADMINIS-TRATION DIRECT NRSING HRS	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	
		10	11	13	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & GENERAL							5.01
5.02	PURCHASING RECEIVING AND STORES							5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL							5.04
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	7,791						10
11	Cafeteria		9,559					11
12	Maintenance of Personnel							12
13	Nursing Administration		201	79,240				13
14	Central Services & Supply							14
15	Pharmacy		196		100			15
16	Medical Records & Library		739			418		16
17	Social Service		89				100	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	7,791	2,120	44,094		302	100	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		520	8,665		78		50
53	Anesthesiology							53
54	Radiology-Diagnostic		224					54
57	CT Scan		211					57
58	MRI		80					58
60	Laboratory		1,102					60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		325			38		65
66	Physical Therapy		310	6,455				66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy		100					67
68	Speech Pathology		8					68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients				100			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		2,118					88
90	Clinic		253					90
91	Emergency		963	20,026				91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	7,791	9,559	79,240	100	418	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)	223,855	354,348	301,380	450,105	542,114	68,997	202
203	Unit Cost Multiplier (Wkst. B, Part I)	28.732512	37.069568	3.803382	4,501.050000	1,296.923445	689.970000	203
204	Cost to be allocated (Per Wkst. B, Part II)	12,120	24,808	5,011	7,444	19,780	1,035	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.555641	2.595251	0.063238	74.440000	47.320574	10.350000	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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

	COST CENTER DESCRIPTIONS	NONPHYSIC. ANESTHET. ASSIGNED TIME						
		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							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							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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	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)	318,625						202
203	Unit Cost Multiplier (Wkst. B, Part I)	3,186.250000						203
204	Cost to be allocated (Per Wkst. B, Part II)	1,740						204
205	Unit Cost Multiplier (Wkst. B, Part II)	17.400000						205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	CODE	LINE NO.	AMOUNT	
	1	2	3	4	

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	3,043,789		3,043,789			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,217,753		1,217,753			50
53	Anesthesiology	380,934		380,934			53
54	Radiology-Diagnostic	1,145,351		1,145,351			54
57	CT Scan	305,034		305,034			57
58	MRI	256,916		256,916			58
60	Laboratory	1,386,681		1,386,681			60
62	Whole Blood & Packed Red Blood Cells	70,188		70,188			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	415,334		415,334			65
66	Physical Therapy	417,619		417,619			66
66.01	CARDIAC REHAB						66.01
67	Occupational Therapy	150,800		150,800			67
68	Speech Pathology	19,144		19,144			68
71	Medical Supplies Charged to Patients	54,315		54,315			71
72	Impl. Dev. Charged to Patients	17,345		17,345			72
73	Drugs Charged to Patients	722,934		722,934			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	2,798,880		2,798,880			88
90	Clinic	261,584		261,584			90
91	Emergency	2,475,027		2,475,027			91
92	Observation Beds (Non-Distinct Part)	140,672		140,672			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	15,280,300		15,280,300			200
201	Less Observation Beds	140,672		140,672			201
202	Total (line 200 minus line 201)	15,139,628		15,139,628			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	1,415,537		1,415,537				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	401,743	3,035,591	3,437,334	0.354273			50
53	Anesthesiology	84,153	579,368	663,521	0.574110			53
54	Radiology-Diagnostic	236,120	3,804,061	4,040,181	0.283490			54
57	CT Scan	187,708	3,594,291	3,781,999	0.080654			57
58	MRI	31,283	1,367,467	1,398,750	0.183675			58
60	Laboratory	552,414	6,434,447	6,986,861	0.198470			60
62	Whole Blood & Packed Red Blood Cells	284,923	76,578	361,501	0.194157			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	476,242	407,381	883,623	0.470035			65
66	Physical Therapy	184,069	916,687	1,100,756	0.379393			66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	131,088	273,778	404,866	0.372469			67
68	Speech Pathology	10,952	6,541	17,493	1.094381			68
71	Medical Supplies Charged to Patients	610,883	22,758	633,641	0.085719			71
72	Impl. Dev. Charged to Patients		51,510	51,510	0.336731			72
73	Drugs Charged to Patients	1,009,629	590,184	1,599,813	0.451887			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	144,951	2,992,862	3,137,813				88
90	Clinic	15,814	223,743	239,557	1.091949			90
91	Emergency	11,889	4,371,883	4,383,772	0.564588			91
92	Observation Beds (Non-Distinct Part)		73,391	73,391	1.916747			92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	5,789,398	28,822,521	34,611,919				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	5,789,398	28,822,521	34,611,919				202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,043,789		3,043,789		3,043,789	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,217,753		1,217,753		1,217,753	50
53	Anesthesiology	380,934		380,934		380,934	53
54	Radiology-Diagnostic	1,145,351		1,145,351		1,145,351	54
57	CT Scan	305,034		305,034		305,034	57
58	MRI	256,916		256,916		256,916	58
60	Laboratory	1,386,681		1,386,681		1,386,681	60
62	Whole Blood & Packed Red Blood Cells	70,188		70,188		70,188	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	415,334		415,334		415,334	65
66	Physical Therapy	417,619		417,619		417,619	66
66.01	CARDIAC REHAB						66.01
67	Occupational Therapy	150,800		150,800		150,800	67
68	Speech Pathology	19,144		19,144		19,144	68
71	Medical Supplies Charged to Patients	54,315		54,315		54,315	71
72	Impl. Dev. Charged to Patients	17,345		17,345		17,345	72
73	Drugs Charged to Patients	722,934		722,934		722,934	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	2,798,880		2,798,880		2,798,880	88
90	Clinic	261,584		261,584		261,584	90
91	Emergency	2,475,027		2,475,027		2,475,027	91
92	Observation Beds (Non-Distinct Part)	140,672		140,672			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	15,280,300		15,280,300		15,139,628	200
201	Less Observation Beds	140,672		140,672			201
202	Total (line 200 minus line 201)	15,139,628		15,139,628		15,139,628	202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

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

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	1,217,753	187,321	1,030,432		50
53	Anesthesiology	380,934	16,487	364,447		53
54	Radiology-Diagnostic	1,145,351	47,950	1,097,401		54
57	CT Scan	305,034	56,950	248,084		57
58	MRI	256,916	6,929	249,987		58
60	Laboratory	1,386,681	39,639	1,347,042		60
62	Whole Blood & Packed Red Blood Cells	70,188	2,236	67,952		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	415,334	16,140	399,194		65
66	Physical Therapy	417,619	20,524	397,095		66
66.01	CARDIAC REHAB					66.01
67	Occupational Therapy	150,800	1,222	149,578		67
68	Speech Pathology	19,144	142	19,002		68
71	Medical Supplies Charged to Patients	54,315	5,103	49,212		71
72	Impl. Dev. Charged to Patients	17,345	120	17,225		72
73	Drugs Charged to Patients	722,934	16,059	706,875		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	2,798,880	93,495	2,705,385		88
90	Clinic	261,584	28,060	233,524		90
91	Emergency	2,475,027	42,462	2,432,565		91
92	Observation Beds (Non-Distinct Part)	140,672	8,072	132,600		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	12,236,511	588,911	11,647,600		200
201	Less Observation Beds	140,672	8,072	132,600		201
202	Total	12,095,839	580,839	11,515,000		202

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

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

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		1,217,753			50
53	Anesthesiology		380,934			53
54	Radiology-Diagnostic		1,145,351			54
57	CT Scan		305,034			57
58	MRI		256,916			58
60	Laboratory		1,386,681			60
62	Whole Blood & Packed Red Blood Cells		70,188			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		415,334			65
66	Physical Therapy		417,619			66
66.01	CARDIAC REHAB					66.01
67	Occupational Therapy		150,800			67
68	Speech Pathology		19,144			68
71	Medical Supplies Charged to Patients		54,315			71
72	Impl. Dev. Charged to Patients		17,345			72
73	Drugs Charged to Patients		722,934			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		2,798,880			88
90	Clinic		261,584			90
91	Emergency		2,475,027			91
92	Observation Beds (Non-Distinct Part)		140,672	73,391	1.916747	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		12,236,511	73,391		200
201	Less Observation Beds		140,672	73,391		201
202	Total		12,095,839			202

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	0.354273		1,289,939			456,991		50
53	Anesthesiology	0.574110		232,309			133,371		53
54	Radiology-Diagnostic	0.283490		971,068			275,288		54
57	CT Scan	0.080654		1,014,503			81,824		57
58	MRI	0.183675		319,649			58,712		58
60	Laboratory	0.198470		2,276,234			451,764		60
62	Whole Blood & Packed Red Blood	0.194157		32,365			6,284		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.470035		150,610			70,792		65
66	Physical Therapy	0.379393		343,908			130,476		66
66.01	CARDIAC REHAB								66.01
67	Occupational Therapy	0.372469		63,124			23,512		67
68	Speech Pathology	1.094381		2,500			2,736		68
71	Medical Supplies Charged to Pat	0.085719		18,241			1,564		71
72	Impl. Dev. Charged to Patients	0.336731		44,475			14,976		72
73	Drugs Charged to Patients	0.451887		327,807			148,132		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	1.091949		72,753			79,443		90
91	Emergency	0.564588		1,154,847			652,013		91
92	Observation Beds (Non-Distinct	1.916747		33,133			63,508		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			8,347,465			2,651,386		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			8,347,465			2,651,386		202

(A) Worksheet A line numbers

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	0.354273							50
53	Anesthesiology	0.574110							53
54	Radiology-Diagnostic	0.283490							54
57	CT Scan	0.080654							57
58	MRI	0.183675							58
60	Laboratory	0.198470							60
62	Whole Blood & Packed Red Blood	0.194157							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.470035							65
66	Physical Therapy	0.379393							66
66.01	CARDIAC REHAB								66.01
67	Occupational Therapy	0.372469							67
68	Speech Pathology	1.094381							68
71	Medical Supplies Charged to Pat	0.085719							71
72	Impl. Dev. Charged to Patients	0.336731							72
73	Drugs Charged to Patients	0.451887							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	1.091949							90
91	Emergency	0.564588							91
92	Observation Beds (Non-Distinct	1.916747							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

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)	174,663	41,118	133,545	1,704	78.37	48	3,762	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)	174,663		133,545	1,704		48	3,762	200

(A) Worksheet A line numbers

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	187,321	3,437,334	0.054496			50
53	Anesthesiology	16,487	663,521	0.024848			53
54	Radiology-Diagnostic	47,950	4,040,181	0.011868			54
57	CT Scan	56,950	3,781,999	0.015058			57
58	MRI	6,929	1,398,750	0.004954			58
60	Laboratory	39,639	6,986,861	0.005673			60
62	Whole Blood & Packed Red Blood	2,236	361,501	0.006185			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	16,140	883,623	0.018266			65
66	Physical Therapy	20,524	1,100,756	0.018645			66
66.01	CARDIAC REHAB						66.01
67	Occupational Therapy	1,222	404,866	0.003018			67
68	Speech Pathology	142	17,493	0.008118			68
71	Medical Supplies Charged to Pat	5,103	633,641	0.008053			71
72	Impl. Dev. Charged to Patients	120	51,510	0.002330			72
73	Drugs Charged to Patients	16,059	1,599,813	0.010038			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	93,495	3,137,813	0.029796			88
90	Clinic	28,060	239,557	0.117133			90
91	Emergency	42,462	4,383,772	0.009686			91
92	Observation Beds (Non-Distinct	8,072	73,391	0.109986			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	588,911	33,196,382				200

(A) Worksheet A line numbers

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

(A) Worksheet A line numbers

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

Check Applicable Boxes:
[ ] Title V [ ] 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)	1,704		48		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)	1,704		48		200

(A) Worksheet A line numbers

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

		Non Physician Anesth-etist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
53	Anesthesiology	318,625						318,625		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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	318,625						318,625		200

(A) Worksheet A line numbers

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

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room								50
53	Anesthesiology								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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1344** **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								50
53	Anesthesiology								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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

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

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,251	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,704	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)	1,601	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	261	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)	261	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	25	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,116	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)	238	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)	238	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)	3,043,789	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)	3,617	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	716,544	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,327,245	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)	2,327,245	37

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

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

		1	
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,365.76	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,524,188	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)	1,524,188	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)	686,907	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	2,211,095	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)	325,051	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	325,051	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	650,102	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)					103	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,365.75	88
89	Observation bed cost (line 87 x line 88) (see instructions)					140,672	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	174,663	3,043,789	0.057383	140,672	8,072	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: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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)	2,251	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,704	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)	1,601	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	261	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)	261	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	25	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	48	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)	3,043,789	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)	3,617	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	716,544	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,327,245	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)	2,327,245	37

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)					1,365.76	38
39	Program general inpatient routine service cost (line 9 x line 38)					65,556	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)					65,556	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)					65,556	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					3,762	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)					3,762	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)					103	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,365.75	88
89	Observation bed cost (line 87 x line 88) (see instructions)					140,672	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	174,663	3,043,789	0.057383	140,672	8,072	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: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		876,449		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.354273	217,332	76,995	50
53	Anesthesiology	0.574110	41,795	23,995	53
54	Radiology-Diagnostic	0.283490	122,923	34,847	54
57	CT Scan	0.080654	107,249	8,650	57
58	MRI	0.183675	23,232	4,267	58
60	Laboratory	0.198470	437,007	86,733	60
62	Whole Blood & Packed Red Blood Cells	0.194157	64,198	12,464	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.470035	263,420	123,817	65
66	Physical Therapy	0.379393	54,226	20,573	66
66.01	CARDIAC REHAB				66.01
67	Occupational Therapy	0.372469	41,058	15,293	67
68	Speech Pathology	1.094381	7,747	8,478	68
71	Medical Supplies Charged to Patients	0.085719	365,436	31,325	71
72	Impl. Dev. Charged to Patients	0.336731			72
73	Drugs Charged to Patients	0.451887	526,714	238,015	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	1.091949			90
91	Emergency	0.564588	2,577	1,455	91
92	Observation Beds (Non-Distinct Part)	1.916747			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,274,914	686,907	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,274,914		202

(A) Worksheet A line numbers

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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	0.354273			50
53	Anesthesiology	0.574110			53
54	Radiology-Diagnostic	0.283490	24,355	6,904	54
57	CT Scan	0.080654	13,130	1,059	57
58	MRI	0.183675			58
60	Laboratory	0.198470	68,490	13,593	60
62	Whole Blood & Packed Red Blood Cells	0.194157	2,464	478	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.470035	93,708	44,046	65
66	Physical Therapy	0.379393	98,853	37,504	66
66.01	CARDIAC REHAB				66.01
67	Occupational Therapy	0.372469	68,612	25,556	67
68	Speech Pathology	1.094381	2,074	2,270	68
71	Medical Supplies Charged to Patients	0.085719	121,594	10,423	71
72	Impl. Dev. Charged to Patients	0.336731			72
73	Drugs Charged to Patients	0.451887	237,854	107,483	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	1.091949			90
91	Emergency	0.564588			91
92	Observation Beds (Non-Distinct Part)	1.916747			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		731,134	249,316	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		731,134		202

(A) Worksheet A line numbers

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	2,651,386			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,651,386			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	2,677,900			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	39,910			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,185,004			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)	1,452,986			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)	1,452,986			30
31	Primary payer payments	201			31
32	Subtotal (line 30 minus line 31)	1,452,785			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)	195,069			34
35	Adjusted reimbursable bad debts (see instructions)	126,795			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	153,669			36
37	Subtotal (see instructions)	1,579,580			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)	1,579,580			40
40.01	Sequestration adjustment (see instructions)	31,592			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	1,169,315			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	378,673			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: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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				1,482,511		1,123,815	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	01/31/2018	37,500	01/31/2018	45,500	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		37,500		45,500	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)				1,520,011		1,169,315	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: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

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

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				658,080			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				658,080			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.

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)	656,603		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)	251,809		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	476		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)	908,412		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	908,412		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	908,412		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	22,430		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)	885,982		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)	885,982		19
19.01	Sequestration adjustment (see instructions)	17,720		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	658,080		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	210,182		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	2,211,095	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,211,095	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,233,206	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)	2,233,206	19
20	Deductibles (exclude professional component)	261,334	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,971,872	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,971,872	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	72,786	25
26	Adjusted reimbursable bad debts (see instructions)	47,311	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	61,477	27
28	Subtotal (sum of lines 24 and 26)	2,019,183	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,019,183	30
30.01	Sequestration adjustment (see instructions)	40,384	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	1,520,011	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	458,788	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] NF**	**[ ] PPS**
	[XX] Title XIX	**[ ] SUB (Other)**	**[ ] ICF/IID**	**[ ] TEFRA**
		[ ] SNF		**[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	65,556		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	65,556		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	65,556		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)	65,556		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)	65,556		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)	65,556		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)	65,556		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	65,556		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)	65,556		40
41	Interim payments	65,522		41
42	Balance due provider/program (line 40 minus line 41)	34		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

BALANCE SHEET **WORKSHEET G**

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	2,502,200				1
2	Temporary investments	193,807				2
3	Notes receivable					3
4	Accounts receivable	3,345,790				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,311,717				6
7	Inventory	300,073				7
8	Prepaid expenses	149,215				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	5,179,368				11
	FIXED ASSETS					
12	Land	20,150				12
13	Land improvements	530,039				13
14	Accumulated depreciation	-356,567				14
15	Buildings	9,253,316				15
16	Accumulated depreciation	-4,315,631				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	512,010				19
20	Accumulated depreciation	-241,812				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	2,800,516				23
24	Accumulated depreciation	-2,213,941				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,261,695				27
28	Accumulated depreciation	-1,094,361				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	6,155,414				30
	OTHER ASSETS					
31	Investments	115,208				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)	115,208				35
36	Total assets (sum of lines 11, 30 and 35)	11,449,990				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	551,930				37
38	Salaries, wages and fees payable	916,755				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	235,418				40
41	Deferred income	69,884				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	222,685				44
45	Total current liabilities (sum of lines 37 thru 44)	1,996,672				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	91,678				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	91,678				50
51	Total liabilities (sum of lines 45 and 50)	2,088,350				51
	CAPITAL ACCOUNTS					
52	General fund balance	9,361,640				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	9,361,640				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	11,449,990				60

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		9,561,976			1
2	Net income (loss) (from Worksheet G-3, line 29)		-172,261			2
3	Total (sum of line 1 and line 2)		9,389,715			3
4	Additions (credit adjustments) (specify)					4
5	TEMPORARILY RESTRICTED					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		9,389,715			11
12	Deductions (debit adjustments) (specify)					12
13	TEMPORARILY RESTRICTED	28,075				13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)		28,075			18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,361,640			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	TEMPORARILY RESTRICTED					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	TEMPORARILY RESTRICTED					13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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	1,348,555		1,348,555	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)	1,565,213		1,565,213	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)	1,565,213		1,565,213	17
18	Ancillary services	4,408,828	28,478,252	32,887,080	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)	144,951	2,992,862	3,137,813	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	6,118,992	31,471,114	37,590,106	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		16,319,501	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)		16,319,501	43

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	37,590,106	1
2	Less contractual allowances and discounts on patients' accounts	22,193,782	2
3	Net patient revenues (line 1 minus line 2)	15,396,324	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	16,319,501	4
5	Net income from service to patients (line 3 minus line 4)	-923,177	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	43,392	6
7	Income from investments	52,443	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	118,025	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	3,759	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)	491,280	24
24.01	Other (UNREALIZED GAINS ON INVESTMENTS)	11,792	24.01
24.02	Other (ASSETS RELEASED FORM RESTRICTIONS)	41,286	24.02
24.03	Other (TRANSFER TO RESTRICTED)	-11,061	24.03
25	Total other income (sum of lines 6-24)	750,916	25
26	Total (line 5 plus line 25)	-172,261	26
29	Net income (or loss) for the period (line 26 minus line 28)	-172,261	29

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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

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	378,031		378,031	-18,823	359,208	-33,094	326,114	1
2	Physician Assistant	81,564		81,564		81,564		81,564	2
3	Nurse Practitioner	429,759		429,759		429,759		429,759	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	668,063		668,063		668,063		668,063	9
10	Subtotal (sum of lines 1 through 9)	1,557,417		1,557,417	-18,823	1,538,594	-33,094	1,505,500	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		12,965	12,965		12,965		12,965	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance		28,330	28,330		28,330		28,330	18
19	Other Health Care Costs		23,664	23,664		23,664		23,664	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		64,959	64,959		64,959		64,959	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,557,417	64,959	1,622,376	-18,823	1,603,553	-33,094	1,570,459	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy		7,128	7,128		7,128		7,128	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)		7,128	7,128		7,128		7,128	28
	FACILITY OVERHEAD								
29	Facility Costs		7,997	7,997	17,757	25,754		25,754	29
30	Administrative Costs		77,853	77,853		77,853		77,853	30
31	Total Facility Overhead (sum of lines 29 and 30)		85,850	85,850	17,757	103,607		103,607	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,557,417	157,937	1,715,354	-1,066	1,714,288	-33,094	1,681,194	32

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

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3499** **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	1.82	8,070	4,200	7,644		1
2	Physician Assistants	0.38	1,149	2,100	798		2
3	Nurse Practitioners	3.38	12,677	2,100	7,098		3
4	Subtotal (sum of lines 1 through 3)	5.58	21,896		15,540	21,896	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)	5.58	21,896			21,896	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)	1,570,459	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	7,128	11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,577,587	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	0.995482	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	103,607	14
15	Parent provider overhead allocated to facility (see instructions)	1,117,686	15
16	Total overhead (sum of lines 14 and 15)	1,221,293	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,221,293	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,215,775	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	2,786,234	20

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form **CMS-2552-10**	Period : From: 07/01/2017 To: 06/30/2018	Run Date: 11/26/2018 Run Time: 15:27 Version: 2018.04 (09/26/2018)

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)	2,786,234	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	15,465	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,770,769	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	21,896	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	21,896	6
7	Adjusted cost per visit (line 3 divided by line 6)	126.54	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	126.54	126.54	126.54	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)	2,372	2,372		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	300,153	300,153		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)		600,306		16
16.01	Total program charges (see instructions)(from contractor's records)		708,246		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		26,408		16.02
16.03	Total program preventive costs (see instructions)		22,383		16.03
16.04	Total program non-preventive costs (see instructions)		406,458		16.04
16.05	Total program cost (see instructions)		428,841		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		69,850		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		113,295		19
20	Net Medicare cost excluding vaccines (see instructions)		428,841		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,976		21
22	Total reimbursable Program cost (line 20 plus line 21)		434,817		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)		434,817		26
26.01	Sequestration adjustment (see instructions)		8,696		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		410,435		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		15,686		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3499** **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)	1,505,500	1,505,500	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)	42	3,124	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	73	5,478	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	115	8,602	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,570,459	1,570,459	6
7	Total overhead (from Wkst. M-2, line 16)	1,215,775	1,215,775	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000073	0.005477	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	89	6,659	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	204	15,261	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	1	355	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	204.00	42.99	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries		139	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)		5,976	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		15,465	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		5,976	16

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	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				410,435	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)				410,435	
	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.