

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☐ Electronically filed cost report 2. ☒ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☒ Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 11/26/2019 Time: 11:02	
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 07/01/2018 and ending 06/30/2019, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

CEO
 Title

 Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT	TITLE XIX	
	TITLE V	PART A	PART B			
	1	2	3	4	5	
1	HOSPITAL	31,256	159,868			1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF	11,512				5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC		8,292			10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	42,768	168,160			200

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete this information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

								Payment System (P, T, O, or N)		
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	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 / 2018	To: 06 / 30 / 2019		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 eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)							37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2 PART I

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

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Facility PPS

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	N			70
71	If line 70 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

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

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

Rural Providers

		1	2	
105	Does this hospital qualify as a CAH?	Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	Y		108
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	N	Physical Occupational Speech Respiratory	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		1 N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	1 N	2	111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-L, chapter 22, section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	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
118.01	List amounts of malpractice premiums and paid losses:	Premiums 147,002	Paid Losses Self Insurance	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

Transplant Center Information

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

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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		Title V	Title XIX	
		Part A	Part B	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

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

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

COMPLETED BY ALL HOSPITALS

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	08/22/2019	Y	08/22/2019	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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

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

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

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

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

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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	33,288.00		1,023	35	1,387	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						576		605	5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	33,288.00		1,599	35	1,992	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	33,288.00		1,599	35	1,992	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					5,054	8,244	23,555	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							73	272	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)								10	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

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

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					269	35	351	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)		116.32			269	35	351	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		22.08						26
27	Total (sum of lines 14-26)		138.40						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

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

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	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

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

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				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 category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				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

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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3499

WORKSHEET S-8

Check applicable box: ☒ 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

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

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.443766	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,646,761	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	10,219,444	6
7	Medicaid cost (line 1 times line 6)	4,535,042	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.	888,281	8

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

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

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

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

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

17	Private grants, donations, or endowment income restricted to fundng charity care		17
18	Government grants, appropriations of transfers for support of hospital operations		18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	888,281	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)	1,075,466	517,157	1,592,623	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	477,255	517,157	994,412	21
22	Payments received from patients for amounts previously written off as charity care	43,555	44,138	87,693	22
23	Cost of charity care (line 21 minus line 22)	433,700	473,019	906,719	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)	687,658	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	138,435	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	212,977	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	474,681	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	285,189	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	1,191,908	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,080,189	31

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

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		494,849	494,849		494,849		494,849	1
2	00200	Cap Rel Costs-Mvble Equip		355,447	355,447		355,447	-91,980	263,467	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department		2,007,864	2,007,864	53,335	2,061,199	-567	2,060,632	4
5.01	00580	ADMINISTRATIVE & GENERAL	336,359	303,211	639,570		639,570	-7,700	631,870	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	77,063	20,803	97,866		97,866	-29,368	68,498	5.02
5.03	01160	COMMUNICATIONS		49,086	49,086		49,086		49,086	5.03
5.04	00590	OTHER ADMINISTRATIVE AND GENERAL	468,813	1,871,460	2,340,273	-53,335	2,286,938	-117,985	2,168,953	5.04
6	00600	Maintenance & Repairs	214,510	176,786	391,296		391,296		391,296	6
7	00700	Operation of Plant		140,238	140,238		140,238		140,238	7
8	00800	Laundry & Linen Service		92,412	92,412		92,412		92,412	8
9	00900	Housekeeping	246,511	34,950	281,461		281,461		281,461	9
10	01000	Dietary	205,320	221,507	426,827	-368,613	58,214		58,214	10
11	01100	Cafeteria				368,613	368,613	-121,368	247,245	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	192,425	5,487	197,912		197,912		197,912	13
14	01400	Central Services & Supply								14
15	01500	Pharmacy	224,027	85,657	309,684		309,684		309,684	15
16	01600	Medical Records & Library	242,220	60,449	302,669		302,669	-5,015	297,654	16
17	01700	Social Service				53,216	53,216		53,216	17
19	01900	Nonphysician Anesthetists				222,172	222,172		222,172	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	1,116,806	44,446	1,161,252	-53,216	1,108,036		1,108,036	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	260,395	220,478	480,873	-16,711	464,162		464,162	50
53	05300	Anesthesiology	222,172	24,494	246,666	-222,172	24,494		24,494	53
54	05400	Radiology-Diagnostic	310,772	444,856	755,628		755,628		755,628	54
57	05700	CT Scan		103,188	103,188		103,188		103,188	57
58	05800	MRI		161,192	161,192		161,192		161,192	58
60	06000	Laboratory	482,794	308,406	791,200		791,200	-26,136	765,064	60
62	06200	Whole Blood & Packed Red Blood Cells		37,213	37,213		37,213		37,213	62
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	190,252	18,946	209,198		209,198	-96	209,102	65
66	06600	Physical Therapy	180,871	9,527	190,398		190,398		190,398	66
66.01	06601	CARDIAC REHAB								66.01
67	06700	Occupational Therapy	92,854	1,736	94,590		94,590		94,590	67
68	06800	Speech Pathology	40,133	199	40,332		40,332		40,332	68
71	07100	Medical Supplies Charged to Patients		22,045	22,045		22,045		22,045	71
72	07200	Impl. Dev. Charged to Patients				16,711	16,711		16,711	72
73	07300	Drugs Charged to Patients		325,507	325,507		325,507	-102,722	222,785	73
76	03020	OTHER ANCILLARY SERVICE COST CENTER								76
76.01	03950	OCCUPATIONAL MEDICINE		4,712	4,712		4,712	-4,712		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	1,656,035	200,430	1,856,465	17,704	1,874,169	-33,282	1,840,887	88
90	09000	Clinic	342,172	287,877	630,049		630,049	-278,325	351,724	90
91	09100	Emergency	489,889	1,400,675	1,890,564		1,890,564	-159,205	1,731,359	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)	7,592,393	9,536,133	17,128,526	17,704	17,146,230	-978,461	16,167,769	118
		NONREIMBURSABLE COST CENTERS								
192	19200	Physicians' Private Offices		24,732	24,732	-17,704	7,028		7,028	192
200		TOTAL (sum of lines 118-199)	7,592,393	9,560,865	17,153,258		17,153,258	-978,461	16,174,797	200

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RECLASSIFICATIONS**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	CAFETERIA RECLASS	A	Cafeteria	11	177,317	191,296
500	Total reclassifications				177,317	191,296
	Code Letter - A					
1	RHC UTILITY RECLASS	B	Rural Health Clinic	88		17,704
500	Total reclassifications					17,704
	Code Letter - B					
1	SALARY RECLASS	C				
500	Total reclassifications					
	Code Letter - C					
1	SALARIES RECLASS	D	Social Service	17	53,216	
500	Total reclassifications				53,216	
	Code Letter - D					
1	SALARIES RECLASS	E	Employee Benefits Department	4	53,335	
500	Total reclassifications				53,335	
	Code Letter - E					
1	CRNA RECLASS	F	Nonphysician Anesthetists	19	222,172	
500	Total reclassifications				222,172	
	Code Letter - F					
1	IMPLANT DEVICE COST RECLASS	G	Impl. Dev. Charged to Patient	72		16,711
500	Total reclassifications					16,711
	Code Letter - G					
	GRAND TOTAL (Increases)				506,040	225,711

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

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RECLASSIFICATIONS**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	CAFETERIA RECLASS	A	Dietary	10	177,317	191,296		1
500	Total reclassifications				177,317	191,296		500
	Code letter - A							
1	RHC UTILITY RECLASS	B	Physicians' Private Offices	192		17,704		1
500	Total reclassifications					17,704		500
	Code letter - B							
1	SALARY RECLASS	C						1
500	Total reclassifications							500
	Code letter - C							
1	SALARIES RECLASS	D	Adults & Pediatrics	30	53,216			1
500	Total reclassifications				53,216			500
	Code letter - D							
1	SALARIES RECLASS	E	OTHER ADMINISTRATIVE AND GENE	5.04	53,335			1
500	Total reclassifications				53,335			500
	Code letter - E							
1	CRNA RECLASS	F	Anesthesiology	53	222,172			1
500	Total reclassifications				222,172			500
	Code letter - F							
1	IMPLANT DEVICE COST RECLASS	G	Operating Room	50		16,711		1
500	Total reclassifications					16,711		500
	Code letter - G							
	GRAND TOTAL (Decreases)				506,040	225,711		

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

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

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	20,150					20,150		1
2	Land Improvements	530,039	25,190		25,190		555,229		2
3	Buildings and Fixtures	9,222,100					9,222,100		3
4	Building Improvements								4
5	Fixed Equipment	512,010					512,010		5
6	Movable Equipment	2,831,683	360,683		360,683	173,691	3,018,675		6
7	HIT-designated Assets	1,261,695					1,261,695		7
8	Subtotal (sum of lines 1-7)	14,377,677	385,873		385,873	173,691	14,589,859		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	14,377,677	385,873		385,873	173,691	14,589,859		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	429,465			59,524	5,860		494,849	1
2	Cap Rel Costs-Mvble Equip	347,132		8,315				355,447	2
3	Total (sum of lines 1-2)	776,597		8,315	59,524	5,860		850,296	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1	2	3	4	5	6	7	8	
*										
1	Cap Rel Costs-Bldg & Fi	10,309,489		10,309,489	0.706620					1
2	Cap Rel Costs-Mvble Equip	4,280,370		4,280,370	0.293380					2
3	Total (sum of lines 1-2)	14,589,859		14,589,859	1.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9	10	11	12	13	14	15	
*									
1	Cap Rel Costs-Bldg & Fixt	429,465			59,524	5,860		494,849	1
2	Cap Rel Costs-Mvble Equip	263,587		-120				263,467	2
3	Total (sum of lines 1-2)	693,052		-120	59,524	5,860		758,316	3

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

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ADJUSTMENTS TO EXPENSES
WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.
		1	2	3	4	5
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1	
2	Investment income-movable equipment (chapter 2)	B	-8,315	Cap Rel Costs-Mvble Equip	2	11
3	Investment income-other (chapter 2)					
4	Trade, quantity, and time discounts (chapter 8)					
5	Refunds and rebates of expenses (chapter 8)	B	-29,337	PURCHASING RECEIVING AND STORES	5.02	
6	Rental of provider space by suppliers (chapter 8)					
7	Telephone services (pay stations excl) (chapter 21)					
8	Television and radio service (chapter 21)					
9	Parking lot (chapter 21)					
10	Provider-based physician adjustment	Wkst A-8-2	-457,333			
11	Sale of scrap, waste, etc. (chapter 23)					
12	Related organization transactions (chapter 10)	Wkst A-8-1				
13	Laundry and linen service					
14	Cafeteria - employees and guests	B	-121,368	Cafeteria	11	
15	Rental of quarters to employees & others					
16	Sale of medical and surgical supplies to other than patients	B	-5,015	Medical Records & Library	16	
17	Sale of drugs to other than patients					
18	Sale of medical records and abstracts					
19	Nursing and allied health education (tuition, fees, books, etc.)					
20	Vending machines					
21	Income from imposition of interest, finance or penalty charges (chapter 21)					
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments					
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65	
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66	
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114	
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1	
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2	
28	Non-physician anesthetist			Nonphysician Anesthetists	19	
29	Physicians' assistant					
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67	
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68	
32	CAH HIT Adj for Depreciation	A	-83,545	Cap Rel Costs-Mvble Equip	2	9
33	PHYSICIAN MALPRACTICE COSTS	A	-18,237	Emergency	91	
33.01	PHYSICIAN MALPRACTICE COSTS	A	-25,480	Clinic	90	
34	SALE OF INSTITUTIONAL MATERIALS	B	-31	PURCHASING RECEIVING AND STORES	5.02	
34.01	340B COSTS	A	-102,722	Drugs Charged to Patients	73	
35	DONATIONS EXPENSE	A	-4,972	OTHER ADMINISTRATIVE AND GENERAL	5.04	
36	MISC REVENUE - ADMIN	A	-4,410	OTHER ADMINISTRATIVE AND GENERAL	5.04	
37	PHYSICIAN RECRUITMENT	A	-57,220	OTHER ADMINISTRATIVE AND GENERAL	5.04	
38	TELEPHONE OFFSET	A	-120	Cap Rel Costs-Mvble Equip	2	11
39	TELEPHONE OFFSET	A	-2,087	OTHER ADMINISTRATIVE AND GENERAL	5.04	
40	TELEPHONE OFFSET	A	-567	Employee Benefits Department	4	
41	LOBBYING EXPENSE	A	-6,939	OTHER ADMINISTRATIVE AND GENERAL	5.04	
42	PART B PHYSICIAN BILING COSTS	A	-7,700	ADMINISTRATIVE & GENERAL	5.01	
43	ADVERTISING - ADMIN	A	-42,357	OTHER ADMINISTRATIVE AND GENERAL	5.04	
44	OCCUPATIONAL MED	A	-706	OCCUPATIONAL MEDICINE	76.01	
45						
46						
47						
48						
49						
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-978,461			

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

(2) Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined

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

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

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

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

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

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

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

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

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

- (1) Use the following symbols to indicate the interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	91	Emergency EMERGENCY	1,295,156	140,968	1,154,188					1
2	90	Clinic CLINIC	252,845	252,845						2
3	60	Laboratory LABORATORY	26,136	26,136						3
4	65	Respiratory Therapy RESPIRATORY THE	96	96						4
5	66.01	CARDIAC REHAB CARDIAC REHAB								5
6	76.01	OCCUPATIONAL MEDICIN OCCUPATIONAL ME	4,006	4,006						6
7	88	Rural Health Clinic RURAL HEALTH CI	408,749	33,282	375,467					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	1,986,988	457,333	1,529,655					200

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	91	Emergency EMERGENCY							140,968	1
2	90	Clinic CLINIC							252,845	2
3	60	Laboratory LABORATORY							26,136	3
4	65	Respiratory Therapy RESPIRATORY THE							96	4
5	66.01	CARDIAC REHAB CARDIAC REHAB								5
6	76.01	OCCUPATIONAL MEDICIN OCCUPATIONAL ME							4,006	6
7	88	Rural Health Clinic RURAL HEALTH CI							33,282	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							457,333	200

KPMG LLP Compu-Max 2552-10

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS**WORKSHEET A-8-3
PARTS I-IV**Check applicable box: ☐ Occupational ☐ Physical ☐ Respiratory ☒ Speech Pathology**PART I - GENERAL INFORMATION**

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					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	Optional travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

KPMG LLP Compu-Max 2552-10

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

Check applicable box: ☐ Occupational ☐ Physical ☐ Respiratory ☒ Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists 1	Assistants 2	Aides 3	Trainees 4	Total 5	
47	Overtime hours worked during reporting period (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						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 in column 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 overtime 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

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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	494,849	494,849					1
2	Cap Rel Costs-Mvble Equip	263,467		263,467				2
4	Employee Benefits Department	2,060,632			2,060,632			4
5.01	ADMINISTRATIVE & GENERAL	631,870	13,228		91,936	737,034		5.01
5.02	PURCHASING RECEIVING AND STORES	68,498	4,345		21,063		93,906	5.02
5.03	COMMUNICATIONS	49,086						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	2,168,953	35,564	41,734	113,562		7,229	5.04
6	Maintenance & Repairs	391,296			58,632		2,203	6
7	Operation of Plant	140,238	98,795					7
8	Laundry & Linen Service	92,412						8
9	Housekeeping	281,461	5,676	1,178	67,378		2,617	9
10	Dietary	58,214	6,414	249	48,466		14,405	10
11	Cafeteria	247,245	14,897	1,214	7,654			11
12	Maintenance of Personnel							12
13	Nursing Administration	197,912	1,975		52,595		81	13
14	Central Services & Supply							14
15	Pharmacy	309,684	2,951		61,233		8,092	15
16	Medical Records & Library	297,654	9,815	895	66,206		182	16
17	Social Service	53,216	313		14,545		56	17
19	Nonphysician Anesthetists	222,172			60,726			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	1,108,036	79,036	17,374	290,709	30,410	2,691	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	464,162	60,425	71,706	71,173	64,968	9,011	50
53	Anesthesiology	24,494	350	17,125		8,636	1,403	53
54	Radiology-Diagnostic	755,628	8,314	28,266	84,943	84,965	4,095	54
57	CT Scan	103,188	5,282	45,574		85,897	796	57
58	MRI	161,192	3,307			24,943	316	58
60	Laboratory	765,064	7,233	11,491	131,961	153,520	14,036	60
62	Whole Blood & Packed Red Blood Cells	37,213	1,188			5,164	500	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	209,102	6,858	598	52,001	19,436	789	65
66	Physical Therapy	190,398	9,827	2,606	49,437	24,522	640	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	94,590			25,380	8,239	28	67
68	Speech Pathology	40,332			10,969	1,418	15	68
71	Medical Supplies Charged to Patients	22,045	3,157			13,649	1,445	71
72	Impl. Dev. Charged to Patients	16,711				1,399		72
73	Drugs Charged to Patients	222,785		6,116		34,590	16,804	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	1,840,887	69,777	7,615	452,638	73,248	3,310	88
90	Clinic	351,724	16,747	1,972	93,525	14,873	305	90
91	Emergency	1,731,359	14,891	5,446	133,900	87,157	2,655	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)	16,167,769	480,365	261,159	2,060,632	737,034	93,732	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	7,028	14,484	2,308			174	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	16,174,797	494,849	263,467	2,060,632	737,034	93,906	202

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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	49,086						5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	5,454	2,372,496	2,372,496				5.04
6	Maintenance & Repairs		452,131	77,717	529,848			6
7	Operation of Plant	1,148	240,209	41,290	118,508	400,007		7
8	Laundry & Linen Service		92,412	15,885			108,297	8
9	Housekeeping	287	358,597	61,640	6,809	8,778		9
10	Dietary	1,435	129,183	22,205	7,694	9,919	7,408	10
11	Cafeteria		271,010	46,584	17,869	23,038		11
12	Maintenance of Personnel							12
13	Nursing Administration	861	253,424	43,561	2,370	3,055		13
14	Central Services & Supply							14
15	Pharmacy	574	382,534	65,754	3,539	4,563		15
16	Medical Records & Library	4,019	378,771	65,107	11,773	15,178		16
17	Social Service	1,148	69,278	11,908	375	483		17
19	Nonphysician Anesthetists		282,898	48,628				19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,325	1,536,581	264,124	94,806	122,230	41,398	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	5,167	746,612	128,336	72,482	93,447	14,146	50
53	Anesthesiology	287	52,295	8,989	420	541		53
54	Radiology-Diagnostic	2,296	968,507	166,478	9,973	12,858	11,037	54
57	CT Scan	287	241,024	41,430	6,336	8,169	2,244	57
58	MRI	287	190,045	32,667	3,967	5,114	2,243	58
60	Laboratory	1,435	1,084,740	186,457	8,676	11,185		60
62	Whole Blood & Packed Red Blood Cells		44,065	7,574	1,425	1,837		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		288,784	49,639	8,226	10,605	722	65
66	Physical Therapy	574	278,004	47,786	11,788	15,197	9,089	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy		128,237	22,043				67
68	Speech Pathology		52,734	9,064				68
71	Medical Supplies Charged to Patients		40,296	6,927	3,787	4,882		71
72	Impl. Dev. Charged to Patients		18,110	3,113				72
73	Drugs Charged to Patients		280,295	48,180				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	10,623	2,458,098	422,531	83,700			88
90	Clinic	2,296	481,442	82,756	20,089	25,900	894	90
91	Emergency	2,583	1,977,991	339,999	17,862	23,028	19,116	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)	49,086	16,150,803	2,368,372	512,474	400,007	108,297	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		23,994	4,124	17,374			192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	49,086	16,174,797	2,372,496	529,848	400,007	108,297	202

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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	435,824						9
10	Dietary	41,829	218,238					10
11	Cafeteria	22,943		381,444				11
12	Maintenance of Personnel							12
13	Nursing Administration	4,108		8,014	314,532			13
14	Central Services & Supply							14
15	Pharmacy	4,258		8,371		469,019		15
16	Medical Records & Library	10,921		23,525			505,275	16
17	Social Service			3,531				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	126,339	218,238	83,469	173,250		299,202	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	65,824		18,447	38,319		167,434	50
53	Anesthesiology			3,967				53
54	Radiology-Diagnostic	7,464		10,354				54
57	CT Scan	7,464		10,354				57
58	MRI	2,304		3,213				58
60	Laboratory	23,545		42,965				60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,418		13,131			23,778	65
66	Physical Therapy	15,229		11,862	24,639			66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy			3,967				67
68	Speech Pathology			1,389				68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients					469,019		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			87,596				88
90	Clinic	19,186		9,561			2,972	90
91	Emergency	74,992		37,728	78,324		11,889	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)	435,824	218,238	381,444	314,532	469,019	505,275	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)	435,824	218,238	381,444	314,532	469,019	505,275	202

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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	85,575					17
19	Nonphysician Anesthetists		331,526				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	85,575		3,045,212		3,045,212	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room			1,345,047		1,345,047	50
53	Anesthesiology		331,526	397,738		397,738	53
54	Radiology-Diagnostic			1,186,671		1,186,671	54
57	CT Scan			317,021		317,021	57
58	MRI			239,553		239,553	58
60	Laboratory			1,357,568		1,357,568	60
62	Whole Blood & Packed Red Blood Cells			54,901		54,901	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy			404,303		404,303	65
66	Physical Therapy			413,594		413,594	66
66.01	CARDIAC REHAB						66.01
67	Occupational Therapy			154,247		154,247	67
68	Speech Pathology			63,187		63,187	68
71	Medical Supplies Charged to Patients			55,892		55,892	71
72	Impl. Dev. Charged to Patients			21,223		21,223	72
73	Drugs Charged to Patients			797,494		797,494	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			3,051,925		3,051,925	88
90	Clinic			642,800		642,800	90
91	Emergency			2,580,929		2,580,929	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)	85,575	331,526	16,129,305		16,129,305	118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices			45,492		45,492	192
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	85,575	331,526	16,174,797		16,174,797	202

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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		13,228		13,228	13,228		5.01
5.02	PURCHASING RECEIVING AND STORES		4,345		4,345		4,345	5.02
5.03	COMMUNICATIONS							5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL		35,564	41,734	77,298		334	5.04
6	Maintenance & Repairs						102	6
7	Operation of Plant		98,795		98,795		1	7
8	Laundry & Linen Service							8
9	Housekeeping		5,676	1,178	6,854		121	9
10	Dietary		6,414	249	6,663		667	10
11	Cafeteria		14,897	1,214	16,111			11
12	Maintenance of Personnel							12
13	Nursing Administration		1,975		1,975		4	13
14	Central Services & Supply							14
15	Pharmacy		2,951		2,951		374	15
16	Medical Records & Library		9,815	895	10,710		8	16
17	Social Service		313		313		3	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		79,036	17,374	96,410	546	125	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		60,425	71,706	132,131	1,166	417	50
53	Anesthesiology		350	17,125	17,475	155	65	53
54	Radiology-Diagnostic		8,314	28,266	36,580	1,525	189	54
57	CT Scan		5,282	45,574	50,856	1,542	37	57
58	MRI		3,307		3,307	448	15	58
60	Laboratory		7,233	11,491	18,724	2,753	649	60
62	Whole Blood & Packed Red Blood Cells		1,188		1,188	93	23	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		6,858	598	7,456	349	37	65
66	Physical Therapy		9,827	2,606	12,433	440	30	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy					148	1	67
68	Speech Pathology					25	1	68
71	Medical Supplies Charged to Patients		3,157		3,157	245	67	71
72	Impl. Dev. Charged to Patients					25		72
73	Drugs Charged to Patients			6,116	6,116	621	777	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		69,777	7,615	77,392	1,315	153	88
90	Clinic		16,747	1,972	18,719	267	14	90
91	Emergency		14,891	5,446	20,337	1,565	123	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)		480,365	261,159	741,524	13,228	4,337	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		14,484	2,308	16,792		8	192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		494,849	263,467	758,316	13,228	4,345	202

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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	77,632						5.04
6	Maintenance & Repairs	2,543	2,645					6
7	Operation of Plant	1,351	591	100,738				7
8	Laundry & Linen Service	520			520			8
9	Housekeeping	2,017	34	2,211		11,237		9
10	Dietary	727	38	2,498	36	1,078	11,707	10
11	Cafeteria	1,524	89	5,802		592		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,426	12	769		106		13
14	Central Services & Supply							14
15	Pharmacy	2,152	18	1,149		110		15
16	Medical Records & Library	2,131	59	3,822		282		16
17	Social Service	390	2	122				17
19	Nonphysician Anesthetists	1,591						19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	8,643	473	30,782	198	3,257	11,707	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,200	362	23,534	68	1,697		50
53	Anesthesiology	294	2	136				53
54	Radiology-Diagnostic	5,448	50	3,238	53	192		54
57	CT Scan	1,356	32	2,057	11	192		57
58	MRI	1,069	20	1,288	11	59		58
60	Laboratory	6,102	43	2,817		607		60
62	Whole Blood & Packed Red Blood Cells	248	7	463				62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,624	41	2,671	3	243		65
66	Physical Therapy	1,564	59	3,827	44	393		66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	721						67
68	Speech Pathology	297						68
71	Medical Supplies Charged to Patients	227	19	1,230				71
72	Impl. Dev. Charged to Patients	102						72
73	Drugs Charged to Patients	1,577						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	13,819	418					88
90	Clinic	2,708	100	6,523	4	495		90
91	Emergency	11,126	89	5,799	92	1,934		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)	77,497	2,558	100,738	520	11,237	11,707	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	135	87					192
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	77,632	2,645	100,738	520	11,237	11,707	202

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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	24,118						11
12	Maintenance of Personnel							12
13	Nursing Administration	507	4,799					13
14	Central Services & Supply							14
15	Pharmacy	529		7,283				15
16	Medical Records & Library	1,487			18,499			16
17	Social Service	223				1,053		17
19	Nonphysician Anesthetists						1,591	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	5,278	2,643		10,954	1,053		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,166	585		6,130			50
53	Anesthesiology	251						53
54	Radiology-Diagnostic	655						54
57	CT Scan	655						57
58	MRI	203						58
60	Laboratory	2,717						60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	830			871			65
66	Physical Therapy	750	376					66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	251						67
68	Speech Pathology	88						68
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients			7,283				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	5,538						88
90	Clinic	605			109			90
91	Emergency	2,385	1,195		435			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)	24,118	4,799	7,283	18,499	1,053		118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices							192
200	Cross Foot Adjustments						1,591	200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	24,118	4,799	7,283	18,499	1,053	1,591	202

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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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	172,069		172,069			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	171,456		171,456			50
53	Anesthesiology	18,378		18,378			53
54	Radiology-Diagnostic	47,930		47,930			54
57	CT Scan	56,738		56,738			57
58	MRI	6,420		6,420			58
60	Laboratory	34,412		34,412			60
62	Whole Blood & Packed Red Blood Cells	2,022		2,022			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	14,125		14,125			65
66	Physical Therapy	19,916		19,916			66
66.01	CARDIAC REHAB						66.01
67	Occupational Therapy	1,121		1,121			67
68	Speech Pathology	411		411			68
71	Medical Supplies Charged to Patients	4,945		4,945			71
72	Impl. Dev. Charged to Patients	127		127			72
73	Drugs Charged to Patients	16,374		16,374			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	98,635		98,635			88
90	Clinic	29,544		29,544			90
91	Emergency	45,080		45,080			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)	739,703		739,703			118
	NONREIMBURSABLE COST CENTERS						
192	Physicians' Private Offices	17,022		17,022			192
200	Cross Foot Adjustments	1,591		1,591			200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	758,316		758,316			202

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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COST ALLOCATION - STATISTICAL BASIS
WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDG & 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		263,588					2
4	Employee Benefits Department			7,539,058				4
5.01	ADMINISTRATIVE & GENERAL	2,116		336,359	36,346,402			5.01
5.02	PURCHASING RECEIVING AND STORES	695		77,063		1,243,979		5.02
5.03	COMMUNICATIONS						171	5.03
5.04	OTHER ADMINISTRATIVE AND GENERAL	5,689	41,753	415,478		95,757	19	5.04
6	Maintenance & Repairs			214,510		29,189		6
7	Operation of Plant	15,804				368	4	7
8	Laundry & Linen Service							8
9	Housekeeping	908	1,179	246,511		34,664	1	9
10	Dietary	1,026	249	177,317		190,822	5	10
11	Cafeteria	2,383	1,215	28,003				11
12	Maintenance of Personnel							12
13	Nursing Administration	316		192,425		1,070	3	13
14	Central Services & Supply							14
15	Pharmacy	472		224,027		107,200	2	15
16	Medical Records & Library	1,570	895	242,220		2,414	14	16
17	Social Service	50		53,216		748	4	17
19	Nonphysician Anesthetists			222,172				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	12,643	17,382	1,063,590	1,499,668	35,649	29	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	9,666	71,739	260,395	3,203,884	119,376	18	50
53	Anesthesiology	56	17,133		425,885	18,582	1	53
54	Radiology-Diagnostic	1,330	28,279	310,772	4,189,987	54,245	8	54
57	CT Scan	845	45,595		4,235,961	10,547	1	57
58	MRI	529			1,230,041	4,190	1	58
60	Laboratory	1,157	11,496	482,794	7,570,715	185,939	5	60
62	Whole Blood & Packed Red Blood Cells	190			254,653	6,628		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,097	598	190,252	958,465	10,457		65
66	Physical Therapy	1,572	2,607	180,871	1,209,298	8,475	2	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy			92,854	406,284	375		67
68	Speech Pathology			40,133	69,931	199		68
71	Medical Supplies Charged to Patients	505			673,103	19,147		71
72	Impl. Dev. Charged to Patients				69,006			72
73	Drugs Charged to Patients		6,119		1,705,786	222,563		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	11,162	7,618	1,656,035	3,612,203	43,854	37	88
90	Clinic	2,679	1,973	342,172	733,448	4,039	8	90
91	Emergency	2,382	5,449	489,889	4,298,084	35,172	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)	76,842	261,279	7,539,058	36,346,402	1,241,669	171	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices	2,317	2,309			2,310		192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	494,849	263,467	2,060,632	737,034	93,906	49,086	202
203	Unit Cost Multiplier (Wkst. B, Part I)	6.251330	0.999541	0.273328	0.020278	0.075488	287.052632	203
204	Cost to be allocated (Per Wkst. B, Part II)				13,228	4,345		204
205	Unit Cost Multiplier (Wkst. B, Part II)				0.000364	0.003493		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

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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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	-2,372,496	13,802,301					5.04
6	Maintenance & Repairs		452,131	70,659				6
7	Operation of Plant		240,209	15,804	41,376			7
8	Laundry & Linen Service		92,412			89,515		8
9	Housekeeping		358,597	908	908		8,700	9
10	Dietary		129,183	1,026	1,026	6,123	835	10
11	Cafeteria		271,010	2,383	2,383		458	11
12	Maintenance of Personnel							12
13	Nursing Administration		253,424	316	316		82	13
14	Central Services & Supply							14
15	Pharmacy		382,534	472	472		85	15
16	Medical Records & Library		378,771	1,570	1,570		218	16
17	Social Service		69,278	50	50			17
19	Nonphysician Anesthetists		282,898					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		1,536,581	12,643	12,643	34,217	2,522	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		746,612	9,666	9,666	11,693	1,314	50
53	Anesthesiology		52,295	56	56			53
54	Radiology-Diagnostic		968,507	1,330	1,330	9,123	149	54
57	CT Scan		241,024	845	845	1,855	149	57
58	MRI		190,045	529	529	1,854	46	58
60	Laboratory		1,084,740	1,157	1,157		470	60
62	Whole Blood & Packed Red Blood Cells		44,065	190	190			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		288,784	1,097	1,097	597	188	65
66	Physical Therapy		278,004	1,572	1,572	7,513	304	66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy		128,237					67
68	Speech Pathology		52,734					68
71	Medical Supplies Charged to Patients		40,296	505	505			71
72	Impl. Dev. Charged to Patients		18,110					72
73	Drugs Charged to Patients		280,295					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		2,458,098	11,162				88
90	Clinic		481,442	2,679	2,679	739	383	90
91	Emergency		1,977,991	2,382	2,382	15,801	1,497	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)	-2,372,496	13,778,307	68,342	41,376	89,515	8,700	118
	NONREIMBURSABLE COST CENTERS							
192	Physicians' Private Offices		23,994	2,317				192
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		2,372,496	529,848	400,007	108,297	435,824	202
203	Unit Cost Multiplier (Wkst. B, Part I)		0.171891	7.498663	9.667609	1.209820	50.094713	203
204	Cost to be allocated (Per Wkst. B, Part II)		77,632	2,645	100,738	520	11,237	204
205	Unit Cost Multiplier (Wkst. B, Part II)		0.005625	0.037433	2.434696	0.005809	1.291609	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

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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	7,721						10
11	Cafeteria		9,615					11
12	Maintenance of Personnel							12
13	Nursing Administration		202	79,440				13
14	Central Services & Supply							14
15	Pharmacy		211		100			15
16	Medical Records & Library		593			510		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	7,721	2,104	43,757		302	100	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		465	9,678		169		50
53	Anesthesiology		100					53
54	Radiology-Diagnostic		261					54
57	CT Scan		261					57
58	MRI		81					58
60	Laboratory		1,083					60
62	Whole Blood & Packed Red Blood Cells							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		331			24		65
66	Physical Therapy		299	6,223				66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy		100					67
68	Speech Pathology		35					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		2,208					88
90	Clinic		241			3		90
91	Emergency		951	19,782		12		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)	7,721	9,615	79,440	100	510	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)	218,238	381,444	314,532	469,019	505,275	85,575	202
203	Unit Cost Multiplier (Wkst. B, Part I)	28.265510	39.671763	3.959366	4,690.190000	990.735294	855.750000	203
204	Cost to be allocated (Per Wkst. B, Part II)	11,707	24,118	4,799	7,283	18,499	1,053	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.516254	2.508372	0.060410	72.830000	36.272549	10.530000	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

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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)	331,526						202
203	Unit Cost Multiplier (Wkst. B, Part I)	3,315.260000						203
204	Cost to be allocated (Per Wkst. B, Part II)	1,591						204
205	Unit Cost Multiplier (Wkst. B, Part II)	15.910000						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

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

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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	3,045,212		3,045,212			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,345,047		1,345,047			50
53	Anesthesiology	397,738		397,738			53
54	Radiology-Diagnostic	1,186,671		1,186,671			54
57	CT Scan	317,021		317,021			57
58	MRI	239,553		239,553			58
60	Laboratory	1,357,568		1,357,568			60
62	Whole Blood & Packed Red Blood Cells	54,901		54,901			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	404,303		404,303			65
66	Physical Therapy	413,594		413,594			66
66.01	CARDIAC REHAB						66.01
67	Occupational Therapy	154,247		154,247			67
68	Speech Pathology	63,187		63,187			68
71	Medical Supplies Charged to Patients	55,892		55,892			71
72	Impl. Dev. Charged to Patients	21,223		21,223			72
73	Drugs Charged to Patients	797,494		797,494			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	3,051,925		3,051,925			88
90	Clinic	642,800		642,800			90
91	Emergency	2,580,929		2,580,929			91
92	Observation Beds (Non-Distinct Part)	365,856		365,856			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	16,495,161		16,495,161			200
201	Less Observation Beds	365,856		365,856			201
202	Total (line 200 minus line 201)	16,129,305		16,129,305			202

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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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	1,300,230		1,300,230				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	305,772	2,898,112	3,203,884	0.419818			50
53	Anesthesiology	50,950	374,935	425,885	0.933909			53
54	Radiology-Diagnostic	226,199	3,963,788	4,189,987	0.283216			54
57	CT Scan	245,948	3,990,013	4,235,961	0.074840			57
58	MRI	31,200	1,198,841	1,230,041	0.194752			58
60	Laboratory	579,904	6,990,811	7,570,715	0.179318			60
62	Whole Blood & Packed Red Blood Cells	184,723	69,930	254,653	0.215591			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	509,049	449,416	958,465	0.421823			65
66	Physical Therapy	202,880	1,006,418	1,209,298	0.342012			66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	111,913	294,371	406,284	0.379653			67
68	Speech Pathology	29,496	40,435	69,931	0.903562			68
71	Medical Supplies Charged to Patients	610,957	62,146	673,103	0.083036			71
72	Impl. Dev. Charged to Patients		69,006	69,006	0.307553			72
73	Drugs Charged to Patients	943,530	762,256	1,705,786	0.467523			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	127,034	3,485,169	3,612,203				88
90	Clinic	80,547	652,901	733,448	0.876408			90
91	Emergency	30,076	4,268,008	4,298,084	0.600484			91
92	Observation Beds (Non-Distinct Part)	3,150	196,288	199,438	1.834435			92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	5,573,558	30,772,844	36,346,402				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	5,573,558	30,772,844	36,346,402				202

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

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,045,212		3,045,212		3,045,212	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,345,047		1,345,047		1,345,047	50
53	Anesthesiology	397,738		397,738		397,738	53
54	Radiology-Diagnostic	1,186,671		1,186,671		1,186,671	54
57	CT Scan	317,021		317,021		317,021	57
58	MRI	239,553		239,553		239,553	58
60	Laboratory	1,357,568		1,357,568		1,357,568	60
62	Whole Blood & Packed Red Blood Cells	54,901		54,901		54,901	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	404,303		404,303		404,303	65
66	Physical Therapy	413,594		413,594		413,594	66
66.01	CARDIAC REHAB						66.01
67	Occupational Therapy	154,247		154,247		154,247	67
68	Speech Pathology	63,187		63,187		63,187	68
71	Medical Supplies Charged to Patients	55,892		55,892		55,892	71
72	Impl. Dev. Charged to Patients	21,223		21,223		21,223	72
73	Drugs Charged to Patients	797,494		797,494		797,494	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	3,051,925		3,051,925		3,051,925	88
90	Clinic	642,800		642,800		642,800	90
91	Emergency	2,580,929		2,580,929		2,580,929	91
92	Observation Beds (Non-Distinct Part)	365,856		365,856			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Subtotal (sum of lines 30 thru 199)	16,495,161		16,495,161		16,129,305	200
201	Less Observation Beds	365,856		365,856			201
202	Total (line 200 minus line 201)	16,129,305		16,129,305		16,129,305	202

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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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	1,300,230		1,300,230				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	305,772	2,898,112	3,203,884	0.419818			50
53	Anesthesiology	50,950	374,935	425,885	0.933909			53
54	Radiology-Diagnostic	226,199	3,963,788	4,189,987	0.283216			54
57	CT Scan	245,948	3,990,013	4,235,961	0.074840			57
58	MRI	31,200	1,198,841	1,230,041	0.194752			58
60	Laboratory	579,904	6,990,811	7,570,715	0.179318			60
62	Whole Blood & Packed Red Blood Cells	184,723	69,930	254,653	0.215591			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	509,049	449,416	958,465	0.421823			65
66	Physical Therapy	202,880	1,006,418	1,209,298	0.342012			66
66.01	CARDIAC REHAB							66.01
67	Occupational Therapy	111,913	294,371	406,284	0.379653			67
68	Speech Pathology	29,496	40,435	69,931	0.903562			68
71	Medical Supplies Charged to Patients	610,957	62,146	673,103	0.083036			71
72	Impl. Dev. Charged to Patients		69,006	69,006	0.307553			72
73	Drugs Charged to Patients	943,530	762,256	1,705,786	0.467523			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	127,034	3,485,169	3,612,203				88
90	Clinic	80,547	652,901	733,448	0.876408			90
91	Emergency	30,076	4,268,008	4,298,084	0.600484			91
92	Observation Beds (Non-Distinct Part)	3,150	196,288	199,438	1.834435			92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (sum of lines 30 thru 199)	5,573,558	30,772,844	36,346,402				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	5,573,558	30,772,844	36,346,402				202

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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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	1,345,047	171,456	1,173,591		50
53	Anesthesiology	397,738	18,378	379,360		53
54	Radiology-Diagnostic	1,186,671	47,930	1,138,741		54
57	CT Scan	317,021	56,738	260,283		57
58	MRI	239,553	6,420	233,133		58
60	Laboratory	1,357,568	34,412	1,323,156		60
62	Whole Blood & Packed Red Blood Cells	54,901	2,022	52,879		62
62.30	BLOOD CLOTting FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	404,303	14,125	390,178		65
66	Physical Therapy	413,594	19,916	393,678		66
66.01	CARDIAC REHAB					66.01
67	Occupational Therapy	154,247	1,121	153,126		67
68	Speech Pathology	63,187	411	62,776		68
71	Medical Supplies Charged to Patients	55,892	4,945	50,947		71
72	Impl. Dev. Charged to Patients	21,223	127	21,096		72
73	Drugs Charged to Patients	797,494	16,374	781,120		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	3,051,925	98,635	2,953,290		88
90	Clinic	642,800	29,544	613,256		90
91	Emergency	2,580,929	45,080	2,535,849		91
92	Observation Beds (Non-Distinct Part)	365,856	20,673	345,183		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal	13,449,949	588,307	12,861,642		200
201	Less Observation Beds	365,856	20,673	345,183		201
202	Total	13,084,093	567,634	12,516,459		202

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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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		1,345,047	3,203,884	0.419818	50
53	Anesthesiology		397,738	425,885	0.933909	53
54	Radiology-Diagnostic		1,186,671	4,189,987	0.283216	54
57	CT Scan		317,021	4,235,961	0.074840	57
58	MRI		239,553	1,230,041	0.194752	58
60	Laboratory		1,357,568	7,570,715	0.179318	60
62	Whole Blood & Packed Red Blood Cells		54,901	254,653	0.215591	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		404,303	958,465	0.421823	65
66	Physical Therapy		413,594	1,209,298	0.342012	66
66.01	CARDIAC REHAB					66.01
67	Occupational Therapy		154,247	406,284	0.379653	67
68	Speech Pathology		63,187	69,931	0.903562	68
71	Medical Supplies Charged to Patients		55,892	673,103	0.083036	71
72	Impl. Dev. Charged to Patients		21,223	69,006	0.307553	72
73	Drugs Charged to Patients		797,494	1,705,786	0.467523	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		3,051,925	3,612,203	0.844893	88
90	Clinic		642,800	733,448	0.876408	90
91	Emergency		2,580,929	4,298,084	0.600484	91
92	Observation Beds (Non-Distinct Part)		365,856	199,438	1.834435	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	OTHER REIMBURSABLE COST CENTERS					
200	Subtotal		13,449,949	35,046,172		200
201	Less Observation Beds		365,856	199,438		201
202	Total		13,084,093	34,846,734		202

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1344

WORKSHEET D
PART V

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

(A)	Cost Center Description	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	0.419818		1,452,905			609,956		50
53	Anesthesiology	0.933909		286,280			267,359		53
54	Radiology-Diagnostic	0.283216		1,160,232			328,596		54
57	CT Scan	0.074840		1,329,958			99,534		57
58	MRI	0.194752		352,239			68,599		58
60	Laboratory	0.179318		2,618,510			469,546		60
62	Whole Blood & Packed Red Blood	0.215591		29,421			6,343		62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.421823		178,394			75,251		65
66	Physical Therapy	0.342012		424,642			145,233		66
66.01	CARDIAC REHAB								66.01
67	Occupational Therapy	0.379653		82,182			31,201		67
68	Speech Pathology	0.903562		10,502			9,489		68
71	Medical Supplies Charged to Pat	0.083036		35,842			2,976		71
72	Impl. Dev. Charged to Patients	0.307553		52,143			16,037		72
73	Drugs Charged to Patients	0.467523		480,083			224,450		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	0.876408		82,061			71,919		90
91	Emergency	0.600484		1,295,840			778,131		91
92	Observation Beds (Non-Distinct	1.834435		90,932			166,809		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			9,962,166			3,371,429		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			9,962,166			3,371,429		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z344

 WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.419818							50
53	Anesthesiology	0.933909							53
54	Radiology-Diagnostic	0.283216							54
57	CT Scan	0.074840							57
58	MRI	0.194752							58
60	Laboratory	0.179318							60
62	Whole Blood & Packed Red Blood	0.215591							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.421823							65
66	Physical Therapy	0.342012							66
66.01	CARDIAC REHAB								66.01
67	Occupational Therapy	0.379653							67
68	Speech Pathology	0.903562							68
71	Medical Supplies Charged to Pat	0.083036							71
72	Impl. Dev. Charged to Patients	0.307553							72
73	Drugs Charged to Patients	0.467523							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	0.876408							90
91	Emergency	0.600484							91
92	Observation Beds (Non-Distinct	1.834435							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	172,069	45,981	126,088	1,659	76.00	35	2,660	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)	172,069		126,088	1,659		35	2,660	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**COMPONENT CCN: 14-1344****WORKSHEET D
PART II**

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

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	171,456	3,203,884	0.053515			50
53	Anesthesiology	18,378	425,885	0.043152			53
54	Radiology-Diagnostic	47,930	4,189,987	0.011439			54
57	CT Scan	56,738	4,235,961	0.013394			57
58	MRI	6,420	1,230,041	0.005219			58
60	Laboratory	34,412	7,570,715	0.004545			60
62	Whole Blood & Packed Red Blood	2,022	254,653	0.007940			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	14,125	958,465	0.014737			65
66	Physical Therapy	19,916	1,209,298	0.016469			66
66.01	CARDIAC REHAB						66.01
67	Occupational Therapy	1,121	406,284	0.002759			67
68	Speech Pathology	411	69,931	0.005877			68
71	Medical Supplies Charged to Pat	4,945	673,103	0.007347			71
72	Impl. Dev. Charged to Patients	127	69,006	0.001840			72
73	Drugs Charged to Patients	16,374	1,705,786	0.009599			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	98,635	3,612,203	0.027306			88
90	Clinic	29,544	733,448	0.040281			90
91	Emergency	45,080	4,298,084	0.010488			91
92	Observation Beds (Non-Distinct	20,673	199,438	0.103656			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	588,307	35,046,172				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

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

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,659		35		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)	1,659		35		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1344

**WORKSHEET D
PART IV**

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
53	Anesthesiology	331,526						331,526		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)	331,526						331,526		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**
COMPONENT CCN: 14-1344
**WORKSHEET D
PART IV**

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

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	3,203,884							50
53	Anesthesiology	425,885	0.778440						53
54	Radiology-Diagnostic	4,189,987							54
57	CT Scan	4,235,961							57
58	MRI	1,230,041							58
60	Laboratory	7,570,715							60
62	Whole Blood & Packed Red Blood	254,653							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	958,465							65
66	Physical Therapy	1,209,298							66
66.01	CARDIAC REHAB								66.01
67	Occupational Therapy	406,284							67
68	Speech Pathology	69,931							68
71	Medical Supplies Charged to Pat	673,103							71
72	Impl. Dev. Charged to Patients	69,006							72
73	Drugs Charged to Patients	1,705,786							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	3,612,203							88
90	Clinic	733,448							90
91	Emergency	4,298,084							91
92	Observation Beds (Non-Distinct	199,438							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	35,046,172							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS
COMPONENT CCN: 14-1344
**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.419818							50
53	Anesthesiology	0.933909							53
54	Radiology-Diagnostic	0.283216							54
57	CT Scan	0.074840							57
58	MRI	0.194752							58
60	Laboratory	0.179318							60
62	Whole Blood & Packed Red Blood	0.215591							62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.421823							65
66	Physical Therapy	0.342012							66
66.01	CARDIAC REHAB								66.01
67	Occupational Therapy	0.379653							67
68	Speech Pathology	0.903562							68
71	Medical Supplies Charged to Pat	0.083036							71
72	Impl. Dev. Charged to Patients	0.307553							72
73	Drugs Charged to Patients	0.467523							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	0.876408							90
91	Emergency	0.600484							91
92	Observation Beds (Non-Distinct	1.834435							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1344****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,264	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,659	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)	1,387	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	303	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)	302	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,023	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)	288	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)	288	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)	3,045,212	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	813,761	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,231,451	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 35 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)	2,231,451	37

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1344****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,345.06 38
39	Program general inpatient routine service cost (line 9 x line 38)						1,375,996 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)						1,375,996 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)					654,513	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,030,509	49
PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53
TARGET AMOUNT AND LIMIT COMPUTATION							
54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63
PROGRAM INPATIENT ROUTINE SWING BED COST							
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)					387,377	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					387,377	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					774,754	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1344

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					272	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,345.06	88
89	Observation bed cost (line 87 x line 88) (see instructions)					365,856	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	172,069	3,045,212	0.056505	365,856	20,673	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1344****WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,264	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,659	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)	1,387	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	303	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)	302	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	35	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)	3,045,212	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)	813,761	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,231,451	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,231,451	37

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1344****WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,345.06	38
39	Program general inpatient routine service cost (line 9 x line 38)						47,077	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)						47,077	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)						47,077	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						2,660	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)						2,660	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)							53
TARGET AMOUNT AND LIMIT COMPUTATION								
54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)							61
62	Relief payment (see instructions)							62
63	Allowable Inpatient cost plus incentive payment (see instructions)							63
PROGRAM INPATIENT ROUTINE SWING BED COST								
64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)							64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)							65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)							66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1344

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P
☐ Title XVIII, Part A
☒ Title XIX - I/P

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					272	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1344

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		815,974		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.419818	143,933	60,426	50
53	Anesthesiology	0.933909	7,113	6,643	53
54	Radiology-Diagnostic	0.283216	148,507	42,060	54
57	CT Scan	0.074840	127,453	9,539	57
58	MRI	0.194752	22,586	4,399	58
60	Laboratory	0.179318	441,718	79,208	60
62	Whole Blood & Packed Red Blood Cells	0.215591	57,083	12,307	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.421823	256,511	108,202	65
66	Physical Therapy	0.342012	80,526	27,541	66
66.01	CARDIAC REHAB				66.01
67	Occupational Therapy	0.379653	47,181	17,912	67
68	Speech Pathology	0.903562	11,410	10,310	68
71	Medical Supplies Charged to Patients	0.083036	342,230	28,417	71
72	Impl. Dev. Charged to Patients	0.307553			72
73	Drugs Charged to Patients	0.467523	501,378	234,406	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	0.876408			90
91	Emergency	0.600484	13,291	7,981	91
92	Observation Beds (Non-Distinct Part)	1.834435	2,814	5,162	92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		2,203,734	654,513	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,203,734		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z344

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.419818	6,284	2,638	50
53	Anesthesiology	0.933909			53
54	Radiology-Diagnostic	0.283216	26,601	7,534	54
57	CT Scan	0.074840	26,235	1,963	57
58	MRI	0.194752	8,221	1,601	58
60	Laboratory	0.179318	92,082	16,512	60
62	Whole Blood & Packed Red Blood Cells	0.215591	1,133	244	62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.421823	139,977	59,046	65
66	Physical Therapy	0.342012	111,729	38,213	66
66.01	CARDIAC REHAB				66.01
67	Occupational Therapy	0.379653	59,418	22,558	67
68	Speech Pathology	0.903562	16,057	14,508	68
71	Medical Supplies Charged to Patients	0.083036	186,819	15,513	71
72	Impl. Dev. Charged to Patients	0.307553			72
73	Drugs Charged to Patients	0.467523	229,166	107,140	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	0.876408			90
91	Emergency	0.600484			91
92	Observation Beds (Non-Distinct Part)	1.834435			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		903,722	287,470	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		903,722		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1344

WORKSHEET D-3

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.419818			50
53	Anesthesiology	0.933909			53
54	Radiology-Diagnostic	0.283216			54
57	CT Scan	0.074840			57
58	MRI	0.194752			58
60	Laboratory	0.179318			60
62	Whole Blood & Packed Red Blood Cells	0.215591			62
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.421823			65
66	Physical Therapy	0.342012			66
66.01	CARDIAC REHAB				66.01
67	Occupational Therapy	0.379653			67
68	Speech Pathology	0.903562			68
71	Medical Supplies Charged to Patients	0.083036			71
72	Impl. Dev. Charged to Patients	0.307553			72
73	Drugs Charged to Patients	0.467523			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	0.876408			90
91	Emergency	0.600484			91
92	Observation Beds (Non-Distinct Part)	1.834435			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**COMPONENT CCN: 14-1344****WORKSHEET E
PART B**Check applicable box: ☒ **Hospital** ☐ **IPF** ☐ **IRF** ☐ **SUB (Other)** ☐ **SNF****PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	3,371,429			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)	3,371,429			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (see instructions)	3,405,143			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)	47,917			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	1,411,459			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)	1,945,767			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)	1,945,767			30
31	Primary payer payments	750			31
32	Subtotal (line 30 minus line 31)	1,945,017			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)	165,453			34
35	Adjusted reimbursable bad debts (see instructions)	107,544			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	165,453			36
37	Subtotal (see instructions)	2,052,561			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)	2,052,561			40
40.01	Sequestration adjustment (see instructions)	41,051			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	1,851,642			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	159,868			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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WORKSHEET E-1
PART I

			INPATIENT PART A		PART B			
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT		
			1	2	3	4		
1	Total interim payments paid to provider			1,557,377		1,621,342	1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero						2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01	01/28/2019	214,000	01/28/2019	230,300	3.01
			.02					3.02
		Program	.03					3.03
		to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.54					3.54
			.55					3.55
			.56					3.56
			.57					3.57
			.58					3.58
			.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		214,000		230,300	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				1,771,377		1,851,642	4
TO BE COMPLETED BY CONTRACTOR								
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)		.01					5.01
			.02					5.02
		Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.54					5.54
			.55					5.55
			.56					5.56
			.57					5.57
			.58					5.58
			.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		.01					6.01
			.02					6.02
7	Total Medicare program liability (see instructions)							7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)			8

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-Z344****WORKSHEET E-1
PART I**

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

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider			930,508		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment			92,400		3.01
	amount based on subsequent revision of the interim					3.02
	rate for the cost reporting period. Also show date of	Program				3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to				3.04
		Provider				3.05
						3.06
						3.07
						3.08
						3.09
						3.10
						3.50
						3.51
		Provider				3.52
		to				3.53
		Program				3.54
						3.55
						3.56
						3.57
						3.58
						3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			92,400		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)			1,022,908		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment					5.01
	after desk review. Also show date of each payment.					5.02
	If none, write 'NONE' or enter a zero. (1)	Program				5.03
		to				5.04
		Provider				5.05
						5.06
						5.07
						5.08
						5.09
						5.10
						5.50
						5.51
		Provider				5.52
		to				5.53
		Program				5.54
						5.55
						5.56
						5.57
						5.58
						5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)					5.99
6	Determined net settlement amount (balance due)					6.01
	based on the cost report (1)					6.02
7	Total Medicare program liability (see instructions)					7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

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

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z344

WORKSHEET E-2

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

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	782,502		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)	290,345		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	576		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,072,847		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,072,847		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,072,847		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	17,316		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,055,531		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)	1,055,531		19
19.01	Sequestration adjustment (see instructions)	21,111		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	1,022,908		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)	11,512		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E-3
PART V****PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT**

1	Inpatient services	2,030,509	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,030,509	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,050,814	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)	2,050,814	19
20	Deductibles (exclude professional component)	242,284	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,808,530	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,808,530	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	47,524	25
26	Adjusted reimbursable bad debts (see instructions)	30,891	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	47,524	27
28	Subtotal (sum of lines 24 and 26)	1,839,421	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,839,421	30
30.01	Sequestration adjustment (see instructions)	36,788	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	1,771,377	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)	31,256	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1344

WORKSHEET E-3
PART VII

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

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

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	47,077		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	47,077		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	47,077		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	47,077		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)	47,077		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)	47,077		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)	47,077		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	47,077		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)	47,077		40
41	Interim payments	47,077		41
42	Balance due provider/program (line 40 minus line 41)			42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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BALANCE SHEET**WORKSHEET G**

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Assets (Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	4,041,860				1
2	Temporary investments	234,819				2
3	Notes receivable					3
4	Accounts receivable	4,014,148				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,322,169				6
7	Inventory	306,235				7
8	Prepaid expenses	342,538				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	7,617,431				11
	FIXED ASSETS					
12	Land	20,150				12
13	Land improvements	530,039				13
14	Accumulated depreciation	-379,130				14
15	Buildings	9,278,457				15
16	Accumulated depreciation	-4,722,481				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	512,010				19
20	Accumulated depreciation	-273,383				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	2,987,504				23
24	Accumulated depreciation	-2,445,958				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets	1,261,695				27
28	Accumulated depreciation	-1,177,906				28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	5,590,997				30
	OTHER ASSETS					
31	Investments	109,708				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)	109,708				35
36	Total assets (sum of lines 11, 30 and 35)	13,318,136				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	617,701				37
38	Salaries, wages and fees payable	1,000,953				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	142,906				40
41	Deferred income	1,150,000				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	922,440				44
45	Total current liabilities (sum of lines 37 thru 44)	3,834,000				45
	LONG TERM LIABILITIES					
46	Mortgage payable					46
47	Notes payable	63,771				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	63,771				50
51	Total liabilities (sum of lines 45 and 50)	3,897,771				51
	CAPITAL ACCOUNTS					
52	General fund balance	9,420,365				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)	9,420,365				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	13,318,136				60

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

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		9,361,640		1
2	Net income (loss) (from Worksheet G-3, line 29)		64,225		2
3	Total (sum of line 1 and line 2)		9,425,865		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)		9,425,865		11
12	Deductions (debit adjustments) (specify)				12
13	TEMPORARILY RESTRICTED	5,500			13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)		5,500		18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,420,365		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

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

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	1,148,188		1,148,188	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	208,977		208,977	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)	1,357,165		1,357,165	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)	1,357,165		1,357,165	17
18	Ancillary services	4,145,886	29,608,226	33,754,112	18
19	Outpatient services				19
20	Rural Health Clinic (RHC)	127,034	3,485,169	3,612,203	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)	5,630,085	33,093,395	38,723,480	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		17,153,258	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)		17,153,258	43

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	38,723,480	1
2	Less contractual allowances and discounts on patients' accounts	23,013,121	2
3	Net patient revenues (line 1 minus line 2)	15,710,359	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	17,153,258	4
5	Net income from service to patients (line 3 minus line 4)	-1,442,899	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	14,219	6
7	Income from investments	59,879	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	121,368	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	5,015	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)	1,275,989	24
24.01	Other (UNREALIZED GAINS ON INVESTMENTS)	19,729	24.01
24.02	Other (ASSETS RELEASED FORM RESTRICTIONS)	12,274	24.02
25	Total other income (sum of lines 6-24)	1,508,473	25
26	Total (line 5 plus line 25)	65,574	26
27	Other expenses (TRANSFER TO RESTRICTED)	1,349	27
28	Total other expenses (sum of line 27 and subscripsts)	1,349	28
29	Net income (or loss) for the period (line 26 minus line 28)	64,225	29

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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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

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**ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS****COMPONENT CCN: 14-3499****WORKSHEET M-1**Check applicable box: ☒ **RHC I** ☐ **FQHC**

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	405,902		405,902		405,902	-33,282	372,620	1
2	Physician Assistant								2
3	Nurse Practitioner	505,019		505,019		505,019		505,019	3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs	745,114		745,114		745,114		745,114	9
10	Subtotal (sum of lines 1 through 9)	1,656,035		1,656,035		1,656,035	-33,282	1,622,753	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		17,750	17,750		17,750		17,750	15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance		29,128	29,128		29,128		29,128	18
19	Other Health Care Costs		15,733	15,733		15,733		15,733	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		62,611	62,611		62,611		62,611	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,656,035	62,611	1,718,646		1,718,646	-33,282	1,685,364	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy		10,371	10,371		10,371		10,371	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)		10,371	10,371		10,371		10,371	28
	FACILITY OVERHEAD								
29	Facility Costs		7,553	7,553	17,704	25,257		25,257	29
30	Administrative Costs		119,895	119,895		119,895		119,895	30
31	Total Facility Overhead (sum of lines 29 and 30)		127,448	127,448	17,704	145,152		145,152	31
32	Total facility costs (sum of lines 22, 28 and 31)	1,656,035	200,430	1,856,465	17,704	1,874,169	-33,282	1,840,887	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.

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

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

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.77	8,062	4,200	7,434		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	4.08	15,493	2,100	8,568		3
4	Subtotal (sum of lines 1 through 3)	5.85	23,555		16,002	23,555	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)	5.85	23,555			23,555	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)	1,685,364	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	10,371	11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,695,735	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)	0.993884	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)	145,152	14
15	Parent provider overhead allocated to facility (see instructions)	1,211,038	15
16	Total overhead (sum of lines 14 and 15)	1,356,190	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,356,190	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,347,896	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	3,033,260	20

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

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LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES**COMPONENT CCN: 14-3499****WORKSHEET M-3**

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	3,033,260	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	15,840	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	3,017,420	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	23,555	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	23,555	6
7	Adjusted cost per visit (line 3 divided by line 6)	128.10	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	128.10	128.10	128.10	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)	2,527	2,527		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	323,709	323,709		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)		647,418		16
16.01	Total program charges (see instructions)(from contractor's records)		787,658		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		36,470		16.02
16.03	Total program preventive costs (see instructions)		29,977		16.03
16.04	Total program non-preventive costs (see instructions)		439,118		16.04
16.05	Total program cost (see instructions)		469,095		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		68,544		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		124,584		19
20	Net Medicare cost excluding vaccines (see instructions)		469,095		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		5,922		21
22	Total reimbursable Program cost (line 20 plus line 21)		475,017		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)		475,017		26
26.01	Sequestration adjustment (see instructions)		9,500		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		457,225		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		8,292		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST**COMPONENT CCN: 14-3499****WORKSHEET M-4**

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,622,753	1,622,753	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.002075	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		3,367	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		5,434	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		8,801	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,685,364	1,685,364	6
7	Total overhead (from Wkst. M-2, line 16)	1,347,896	1,347,896	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.005222	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		7,039	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)		15,840	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)		345	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)		45.91	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries		129	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)		5,922	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)		15,840	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)		5,922	16

KPMG LLP Compu-Max 2552-10

LAWRENCE COUNTY MEMORIAL HOSPITAL Provider CCN: 14-1344	In Lieu of Form CMS-2552-10	Period : From: 07/01/2018 To: 06/30/2019	Run Date: 11/26/2019 Run Time: 11:02 Version: 2018.12 (10/21/2019)
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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: ☒ RHC I ☐ FQHC

			Part B		
DESCRIPTION			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to provider			457,225	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			457,225	
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter zero (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (1)	.01			6.01
		.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.