COMPUTATION OF RATIO OF COSTS TO CHARGES		PROVIDER NO.: _____		PERIOD: FROM _____ TO _____		WORKSHEET C, PART I	
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 27)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
25	Adults and Pediatrics (General Routine Care)						25
26	Intensive Care Unit						26
27	Coronary Care Unit						27
28	Burn Intensive Care Unit						28
29	Surgical Intensive Care Unit						29
30	Other Special Care (specify)						30
31	Subprovider						31
33	Nursery						33
34	Skilled Nursing Facility						34
35	Other Nursing Facility						35
36	Other Long Term Care						36
	ANCILLARY SERVICE COST CENTERS						
37	Operating Room						37
38	Recovery Room						38
39	Delivery Room and Labor Room						39
40	Anesthesiology						40
41	Radiology-Diagnostic						41
42	Radiology-Therapeutic						42
43	Radioisotope						43
44	Laboratory						44
45	PBP Clinical Laboratory Services-Prgm. Only						45
46	Whole Blood & Packed Red Blood Cells						46
47	Blood Storing, Processing, & Trans.						47
48	Intravenous Therapy						48
49	Respiratory Therapy						49
50	Physical Therapy						50
51	Occupational Therapy						51
52	Speech Pathology						52
53	Electrocardiology						53
54	Electroencephalography						54
55	Medical Supplies Charged to Patients						55
55.30	*Implantable Devices Charged to Patients*						*55.30*
56	Drugs Charged to Patients						56
57	Renal Dialysis						57
58	ASC (Non-Distinct Part)						58
59	Other Ancillary (specify)						59
	OUTPATIENT SERVICE COST CENTERS						
60	Clinic						60
61	Emergency						61
62	Observation Beds (see instructions)						62
63	Other Outpatient Service (specify)						63
	OTHER REIMBURSABLE COST CENTERS						
64	Home Program Dialysis						64
65	Ambulance Services						65
66	Durable Medical Equipment-Rented						66
67	Durable Medical Equipment-Sold						67
68	Other Reimbursable (specify)						68
101	Subtotal (sum of lines 25 thru 68)						101
102	Less Observation Beds						102
103	Total (line 101 minus line 102)						103

FORM CMS-2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3620 & 3620.1)

COMPUTATION OF RATIO OF COSTS TO CHARGES	PROVIDER NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET C, PART I (CONT.)

	COST CENTER DESCRIPTIONS	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
25	Adults and Pediatrics (General Routine Care)							25
26	Intensive Care Unit							26
27	Coronary Care Unit							27
28	Burn Intensive Care Unit							28
29	Surgical Intensive Care Unit							29
30	Other Special Care (specify)							30
31	Subprovider							31
33	Nursery							33
34	Skilled Nursing Facility							34
35	Other Nursing Facility							35
36	Other Long Term Care							36
	ANCILLARY SERVICE COST CENTERS							
37	Operating Room							37
38	Recovery Room							38
39	Delivery Room and Labor Room							39
40	Anesthesiology							40
41	Radiology-Diagnostic							41
42	Radiology-Therapeutic							42
43	Radioisotope							43
44	Laboratory							44
45	PBP Clinical Laboratory Services-Prgm. Only							45
46	Whole Blood & Packed Red Blood Cells							46
47	Blood Storing, Processing, & Trans.							47
48	Intravenous Therapy							48
49	Respiratory Therapy							49
50	Physical Therapy							50
51	Occupational Therapy							51
52	Speech Pathology							52
53	Electrocardiology							53
54	Electroencephalography							54
55	Medical Supplies Charged to Patients							55
55.30	*Implantable Devices Charged to Patients*							*55.30*
56	Drugs Charged to Patients							56
57	Renal Dialysis							57
58	ASC (Non-Distinct Part)							58
59	Other Ancillary (specify)							59
	OUTPATIENT SERVICE COST CENTERS							
60	Clinic							60
61	Emergency							61
62	Observation Beds (see instructions)							62
63	Other Outpatient Service (specify)							63
	OTHER REIMBURSABLE COST CENTERS							
64	Home Program Dialysis							64
65	Ambulance Services							65
66	Durable Medical Equipment-Rented							66
67	Durable Medical Equipment-Sold							67
68	Other Reimbursable (specify)							68
101	Subtotal (sum of lines 25 thru 68)							101
102	Less Observation Beds							102
103	Total (line 101 minus line 102)							103