07-09		FORM CMS-2552-96					3690 (Cont.)	
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. 2	Total Costs 3	RCE Dis- allowance 4	Total Costs 5		
	INPATIENT ROUTINE SERVICE COST CENTERS	1	2	5		5		
25	Adults and Pediatrics (General Routine Care)						25	
26	Intensive Care Unit						26	
27	Coronary Care Unit						27	
	Burn Intensive Care Unit						28	
-	Surgical Intensive Care Unit			_			29	
	Other Special Care (specify)					-	30	
	Subprovider			_			31	
	Nursery Skilled Nursing Facility				-	+	33 34	
	Other Nursing Facility				1		35	
	Other Long Term Care				1	1	36	
	ANCILLARY SERVICE COST CENTERS							
37	Operating Room						37	
38	Recovery Room						38	
39	Delivery Room and Labor Room						39	
-	Anesthesiology						40	
	Radiology-Diagnostic			_			41	
	Radiology-Therapeutic			_			42	
	Radioisotope			-			43	
	Laboratory			_			44 45	
	PBP Clinical Laboratory Services-Prgm. Only Whole Blood & Packed Red Blood Cells						45	
	Blood Storing, Processing, & Trans.				1		40	
	Intravenous Therapy						48	
-	Respiratory Therapy						49	
	Physical Therapy						50	
51	Occupational Therapy						51	
52	Speech Pathology						52	
	Electrocardiology						53	
	Electroencephalography			_			54	
	Medical Supplies Charged to Patients				-		55	
55.30	Implantable Devices Charged to Patients Drugs Charged to Patients				 		55.30	
	Drugs Charged to Patients Renal Dialysis						56 57	
-	ASC (Non-Distinct Part)				1		58	
	Other Ancillary (specify)				1	1	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							
	Home Program Dialysis						64	
-	Ambulance Services				+	+	65	
	Durable Medical Equipment-Rented						66	
	Durable Medical Equipment-Sold Other Reimbursable (specify)				 		67 68	
	Subtotal (sum of lines 25 thru 68)			+	+	+	101	
	Less Observation Beds						101	
-	Total (line 101 minus line 102)						102	
105				1		1	105	

 Item (me for minus me for)
 Item (me for minus me for)

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

3690 (Cont.)	FORM CMS-2552-96					07-09	
COMPUTATION OF RATIO OF COSTS TO CHARGES	PROVIDER NO.:			PERIOD:		WORKSHEET C,	
				FROM TO		PART I (CONT.)	
		Charges					
		Charges	Total	1 1	TEFRA	PPS	
COST CENTER DESCRIPTIONS			(col. 6	Cost or	Inpatient	Inpatient	
	Inpatient	Outpatient	+ col. 7)	Other Ratio	Ratio	Ratio	
	6	7	8	9	10	11	
INPATIENT ROUTINE SERVICE COST CENTI	ERS						
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				1			37
38 Recovery Room 39 Delivery Room and Labor Room							38 39
40 Anesthesiology							40
41 Radiology-Diagnostic							40
42 Radiology-Diagnostic 42 Radiology-Therapeutic							41
43 Radioisotope							43
44 Laboratory				1 1			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				\downarrow \downarrow			57
58 ASC (Non-Distinct Part)				<u> </u>			58
59 Other Ancillary (specify)							59
OUTPATIENT SERVICE COST CENTERS							
60 Clinic	 			<u> </u>			60
61 Emergency	ļ						61
62 Observation Beds (see instructions)	<u> </u>			┥──┤			62
63 Other Outpatient Service (specify)				<u> </u>	_		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

FORM CMS-2552-96 (07/2009) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3620 & 3620.1) 36-562 Rev. 20