

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT  
 CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
 PARTS I & II

INTERMEDIARY [ ] AUDITED DATE RECEIVED \_\_\_\_\_ [ ] INITIAL [ ] RE-OPENING  
 USE ONLY: [ ] DESK REVIEWED INTERMEDIARY NO. \_\_\_\_\_ [ ] FINAL [ ] MCR CODE

PART I - CERTIFICATION

CHECK \_\_\_\_\_ ELECTRONICALLY FILED COST REPORT DATE: \_\_\_\_\_  
 APPLICABLE BOX \_\_\_\_\_ MANUALLY SUBMITTED COST REPORT TIME: \_\_\_\_\_

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE 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 SALEM TOWNSHIP HOSPITAL (14-1345) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 04/01/2007 AND ENDING 03/31/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

(SIGNED) \_\_\_\_\_  
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	2	3	4	1
2	SUBPROVIDER I	108689	172814	422887	2
3	SWING BED - SNF	55000			3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	RURAL HEALTH CLINIC I		16272		9
100	TOTAL	163689	189086	422887	100

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 657 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: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.



HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: ENDING:				26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS): BEGINNING: ENDING: BEGINNING: ENDING:				26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.	YES	12/17/1986		27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02
<p>A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 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. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)</p>					
28.03	STAFFING	0.00		N	28.03
28.04	RECRUITMENT	0.00		N	28.04
28.05	RETENTION OF EMPLOYEES	0.00		N	28.05
28.06	TRAINING	0.00		N	28.06
28.07	OTHER (SPECIFY)				28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	NO			29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.	YES			30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.	NO			30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?	NO			30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)	NO			30.03
30.04	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. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.	NO			30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	NO			31
MISCELLANEOUS COST REPORTING INFORMATION					
32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	NO			32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.	NO			33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?	NO			34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	NO			35
<p style="text-align: right;">V XVIII XIX</p> <p style="text-align: right;">1 2 3</p>					
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL					
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	36
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?				36.01
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?				37.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? YES 38  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? NO 38.01  
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? NO 38.02  
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? NO 38.03  
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? NO 38.04

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE. NO 40

40.01 NAME: FI/CONTRACTOR'S NAME: FI/CONTRACTOR'S NUMBER: 40.01  
 40.02 STREET: P.O.BOX: 40.02  
 40.03 CITY: STATE: ZIP CODE: 40.03

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? YES 41  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42.01  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42.02  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS? NO 43  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY? NO 44  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? NO 45  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.

45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? 45.01  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? 45.02  
 45.03 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? 45.03  
 46 IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE. 46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC	
	1	2	3	4	5	
47 HOSPITAL	Y	Y	N	N	N	47
48 SUBPROVIDER I	N	N	N	N	N	48
49 SKILLED NURSING FACILITY	N	N				49
50 HOME HEALTH AGENCY	N	N				50
52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?				NO		52
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.				NO		52.01
53 IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.						53
53.01 MDH PERIOD: BEGINNING: ENDING:						53.01
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: AND/OR SELF INSURANCE: PREMIUMS: 236779 PAID LOSSES:						54
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.				NO		54.01
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.				NO		55
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.				DATE / / Y/N 1 NO LIMIT 2 0.00 Y/N 3 NO FEES 4		56
57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?				NO		57
58 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.				NO		58
58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01
59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)				NO		59

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
(CONTINUED)

60 ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? NO 60  
ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A  
NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)

60.01 IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT 60.01  
COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N'  
FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH  
42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2  
IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST  
REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE  
SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)

MULTICAMPUS

61 DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. NO 61  
IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2,  
ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

COUNTY:	STATE:	ZIP CODE	CBSA	FTE/ CAMPUS
1	2	3	4	5





HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS
	TITLE V	TITLE XVIII	TITLE XIX	TITLE XV	
	12	13	14	15	
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		679	73	980	1
2 HMO XIX					2
3 HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4 HOSPITAL ADULTS & PEDS - SWING BED NF					4
5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6 INTENSIVE CARE UNIT					6
7 CORONARY CARE UNIT					7
8 BURN INTENSIVE CARE UNIT					8
9 SURGICAL INTENSIVE CARE UNIT					9
10 OTHER SPECIAL CARE (SPECIFY)					10
11 NURSERY					11
12 TOTAL HOSPITAL		679	73	980	12
13 RPCH VISITS					13
14 SUBPROVIDER I					14
15 SKILLED NURSING FACILITY					15
16 NURSING FACILITY					16
17 OTHER LONG TERM CARE					17
18 HOME HEALTH AGENCY					18
20 ASC (DISTINCT PART)					20
21 HOSPICE (DISTINCT PART)					21
23 O/P REHAB PROVIDER					23
24 RHC I					24
25 TOTAL					25
26 OBSERVATION BED DAYS					26
27 AMBULANCE TRIPS					27
28 EMPLOYEE DISCOUNT DAYS					28

HOSPITAL WAGE INDEX INFORMATION

PART II - WAGE DATA	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST.	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	WORKSHEET S-3 PART II
		A-6	3	4	5		
1 SALARIES							
1 TOTAL SALARIES	6594651			362131.00			1
2 NON-PHYSICIAN ANESTHETIST PART A							2
3 NON-PHYSICIAN ANESTHETIST PART B							3
4 PHYSICIAN - PART A							4
4.01 TEACHING PHYSICIAN SALARIES							4.01
5 PHYSICIAN - PART B							5
5.01 NON-PHYSICIAN - PART B							5.01
6 INTERNS & RESIDENTS (IN APPR PGM)							6
6.01 CONTRACT SERVICES, I&R							6.01
7 HOME OFFICE PERSONNEL							7
8 SNF							8
8.01 EXCLUDED AREA SALARIES	224668			16145.00			8.01
9 OTHER WAGES & RELATED COSTS							9
9.01 CONTRACT LABOR							9.01
9.02 PHARMACY SERVICES UNDER CONTRACT							9.02
9.03 LABORATORY SERVICES UNDER CONTRACT							9.03
9.03 MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10 CONTRACT LABOR: PHYSICIAN PART A							10
10.01 TEACHING PHYSICIAN UNDER CONTRACT							10.01
11 HOME OFFICE SALARIES & WAGE REL COSTS							11
12 HOME OFFICE: PHYSICIAN PART A							12
12.01 TEACHING PHYSICIAN SALARIES							12.01
13 WAGE-RELATED COSTS							13
13 WAGE RELATED COSTS (CORE)	1662289					CMS 339	13
14 WAGE RELATED COSTS (OTHER)						CMS 339	14
15 EXCLUDED AREAS	96966					CMS 339	15
16 NON-PHYSICIAN ANESTHETIST PART A						CMS 339	16
17 NON-PHYSICIAN ANESTHETIST PART B						CMS 339	17
18 PHYSICIAN PART A						CMS 339	18
18.01 PART A TEACHING PHYSICIANS						CMS 339	18.01
19 PHYSICIAN PART B						CMS 339	19
19.01 WAGE RELATED COSTS (RHC/FQHC)						CMS 339	19.01
20 INTERNS & RESIDENTS (IN APPR PGM)							20
21 OVERHEAD COSTS - DIRECT SALARIES							21
21 EMPLOYEE BENEFITS	67980			2094.00			21
22 ADMINISTRATIVE & GENERAL	878544			47715.00			22
22.01 ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23 MAINTENANCE & REPAIRS							23
24 OPERATION OF PLANT	173307			10388.00			24
25 LAUNDRY & LINEN SERVICE	32340			1757.00			25
26 HOUSEKEEPING	148646			16360.00			26
26.01 HOUSEKEEPING UNDER CONTRACT							26.01
27 DIETARY	229623	-171781		6318.00			27
27.01 DIETARY UNDER CONTRACT							27.01
28 CAFETERIA		171781		17917.00			28
29 MAINTENANCE OF PERSONNEL							29
30 NURSING ADMINISTRATION	109005			4168.00			30
31 CENTRAL SERVICES AND SUPPLY	84457	-9016		7622.00			31
32 PHARMACY	42432			3508.00			32
33 MEDICAL RECORDS & MEDICAL RECORDS LIBR	240251			19093.00			33
34 SOCIAL SERVICE	41458			1486.00			34
35 OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART III

PART III - HOSPITAL WAGE INDEX SUMMARY	AMOUNT REPORTED	RECLASS. OF SALARIES FROM WKST.	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	WORKSHEET S-3 PART III
		A-6	3	4	5	
1 NET SALARIES	6594651		6594651	362131.00	18.21	1
2 EXCLUDED AREA SALARIES	224668		224668	16145.00	13.92	2
3 SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	6369983		6369983	345986.00	18.41	3
4 SUBTOTAL OTHER WAGES & REL COSTS						4
5 SUBTOTAL WAGE-RELATED COSTS	1662289		1662289		26.10	5
6 TOTAL (SUM OF LINES 3 THRU 5)	8032272		8032272	345986.00	23.22	6
7 NET SALARIES						7
8 EXCLUDED AREA SALARIES						8
9 SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10 SUBTOTAL OTHER WAGES & REL COSTS						10
11 SUBTOTAL WAGE-RELATED COSTS						11
12 TOTAL (SUM OF LINES 9 THRU 11)						12
13 TOTAL OVERHEAD COSTS	2048043	-9016	2039027	138426.00	14.73	13

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA NO.: 14-7429

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1 HOME HEALTH AIDE HOURS	1	208			209	1
2 UNDUPLICATED CENSUS COUNT		135.00		26.00	161.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK:	STAFF 1	CONTRACT 2	TOTAL 3	
40.00				
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4 DIRECTORS AND ASSISTANT DIRECTOR(S)	1.00		1.00	4
5 OTHER ADMINISTRATIVE PERSONNEL	1.01		1.01	5
6 DIRECT NURSING SERVICE	2.63		2.63	6
7 NURSING SUPERVISOR				7
8 PHYSICAL THERAPY SERVICE				8
9 PHYSICAL THERAPY SUPERVISOR				9
10 OCCUPATIONAL THERAPY SERVICE				10
11 OCCUPATIONAL THERAPY SUPERVISOR				11
12 SPEECH PATHOLOGY SERVICE				12
13 SPEECH PATHOLOGY SUPERVISOR				13
14 MEDICAL SOCIAL SERVICE				14
15 MEDICAL SOCIAL SERVICE SUPERVISOR				15
16 HOME HEALTH AIDE	.14		.14	16
17 HOME HEALTH AIDE SUPERVISOR				17
18 OTHER (SPECIFY)				18

HOME HEALTH AGENCY MSA CODES

19 HOW MANY MSAs IN COLUMN 1 OR CBSAs IN COLUMN 1.01 DID YOU PROVIDE SERVICES TO DURING THIS COST REPORTING PERIOD	1	1	1.01	19
20 LIST THOSE MSA CODE(S) IN COLUMN 1 AND CBSA CODE(S) IN COLUMN 1.01 SERVICED DURING THIS COST REPORTING PERIOD (LINE 20 CONTAINS THE FIRST CODE)		9914		20



NHCMQ DEMONSTRATION STATISTICAL DATA  
 STATISTICAL DATA

WORKSHEET S-7

GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1		SERVICES ON OR AFTER JANUARY 1		TOTAL
		RATE	DAYS	RATE	DAYS	
1	2	3	3.01	4	4.01	5
1	RVC/RUC					1
2	RVB/RUB					2
3	RVA/RUA					3
3.01	RUX					3.01
3.02	RUL					3.02
4	RHD/RVC					4
5	RHC/RVB					5
6	RHB/RVA					6
6.01	RVX					6.01
6.02	RVL					6.02
7	RHA/RHC					7
8	RMC/RHB					8
9	RMB/RHA					9
9.01	RHX					9.01
9.02	RHL					9.02
10	RMA/RMC					10
11	RLB/RMB					11
12	RLA/RMA					12
12.01	RMX					12.01
12.02	RML					12.02
13	SE3/RLB					13
14	SE2/RLA					14
14.01	RLX					14.01
15	SE1/SE3					15
16	SSC/SE2					16
17	SSB/SE1					17
18	SSA/SSC					18
19	CD2/SSB					19
20	CD1/SSA					20
21	CC2					21
22	CC1					22
23	CB2					23
24	CB1					24
25	CA2					25
26	CA1					26
27	IB2					27
28	IB1					28
29	IA2					29
30	IA1					30
31	BB2					31
32	BB1					32
33	BA2					33
34	BA1					34
35	PE2					35
36	PE1					36
37	PD2					37
38	PD1					38
39	PC2					39
40	PC1					40
41	PB2					41
42	PB1					42
43	PA2					43
44	PA1					44
45	DEFAULT RATE					45
46	TOTAL					46

PROVIDER-BASED RURAL HEALTH CLINIC/  
 FEDERALLY QUALIFIED HEALTH CENTER  
 PROVIDER STATISTICAL DATA

RHC I  
 COMPONENT NO: 14-3413

WORKSHEET S-8

CHECK APPLICABLE BOX: [ XX ] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1201 RICKER DRIVE 1  
 1.01 CITY: SALEM STATE: IL ZIP CODE: 62881 COUNTY: MARION 1.01  
 2 DESIGNATION (FOR FQHCs ONLY) - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 2

SOURCE OF FEDERAL FUNDS:

GRANT AWARD

DATE

	1	2	
3 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT)	/	/	3
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)	/	/	4
5 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT)	/	/	5
6 APPALACHIAN REGIONAL COMMISSION	/	/	6
7 LOOK-ALIKES	/	/	7
8 OTHER	/	/	8

PHYSICIAN INFORMATION:

PHYSICIAN NAME

BILLING NO.

9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT 9  
 9.01 ACUTE CARE PHYS SVC 3350 9.01

PHYSICIAN NAME

HOURS

10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD 10

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? NO 11  
 IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2  
 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS)

FACILITY HOURS OF OPERATIONS (1)

12 CLINIC	TYPE OPERATION 0	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY		12
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	
		1100	1900	1100	1900	1100	1900	1100	1900	1100	1900	1100	1900	1100	1900	

(1) ENTER CLINIC HRS OF OPERATION ON LNE 12 & OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LNE 12 (BOTH TYPE & HRS 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.

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? NO 13

14 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB 27, SECTION 508(D)? NO 14

IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT.  
 LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.  
 15 PROVIDER NAME: PROVIDER NUMBER: - XVIII XIX 15

16 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS? IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF MEDICARE VISITS PERFORMED BY INTERNS AND RESIDENTS. NO 16

17 HAS THE HOSPITAL'S BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, SEE INSTRUCTIONS. NO 17

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL 3	RECLASSI- FICATIONS 4	RECLASS. TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXP FOR ALLOCATION 7	
GENERAL SERVICE COST CENTERS									
1	0100 OLD CAP REL COSTS-BLDG & FIXT								1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP								2
3	0300 NEW CAP REL COSTS-BLDG & FIXT		515922	515922	51977	567899		567899	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		728989	728989	347146	1076135	-439	1075696	4
5	0500 EMPLOYEE BENEFITS	67980	1719618	1787598		1787598	-45014	1742584	5
6.01	0662 ADMINISTRATIVE & ACCOUNTING	393842	2005723	2399565	-61492	2338073	-1385774	952299	6.01
6.02	0661 BUSINESS SERVICES	484702	279314	764016		764016	-28622	735394	6.02
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT	173307	553760	727067	-1697	725370		725370	8
9	0900 LAUNDRY & LINEN SERVICE	32340	24218	56558		56558		56558	9
10	1000 HOUSEKEEPING	148646	63766	212412		212412		212412	10
11	1100 DIETARY	229623	327227	556850	-417378	139472	-23011	116461	11
12	1200 CAFETERIA				416580	416580	-99755	316825	12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION	109005	17176	126181		126181		126181	14
15	1500 CENTRAL SERVICES & SUPPLY								15
15.01	1501 PURCHASING	75065	14376	89441		89441		89441	15.01
15.02	1502 CENTRAL SERVICES & SUPPLY	9392	430929	440321	-423105	17216		17216	15.02
16	1600 PHARMACY	42432	798526	840958		840958		840958	16
17	1700 MEDICAL RECORDS & LIBRARY	240251	77126	317377		317377	-183	317194	17
18	1800 SOCIAL SERVICE	41458	4443	45901		45901		45901	18
20	2000 NONPHYSICIAN ANESTHETISTS				393056	393056	-393056		20
21	2100 NURSING SCHOOL								21
22	2200 I&R SERVICES-SALARY & FRINGES A								22
23	2300 I&R SERVICES-OTHER PRGM COSTS A								23
24	2400 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS									
25	2500 ADULTS & PEDIATRICS	1417790	157312	1575102	-1044	1574058		1574058	25
26	2600 INTENSIVE CARE UNIT								26
ANCILLARY SERVICE COST CENTERS									
37	3700 OPERATING ROOM	560808	318915	879723	-72104	807619	-43555	764064	37
40	4000 ANESTHESIOLOGY	165304	283383	448687	-448687				40
41	4100 RADIOLOGY-DIAGNOSTIC	580837	709007	1289844	-193828	1096016		1096016	41
44	4400 LABORATORY	476678	764352	1241030	-100	1240930		1240930	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900 RESPIRATORY THERAPY	236911	198235	435146	-37329	397817	-52558	345259	49
50	5000 PHYSICAL THERAPY		582824	582824		582824		582824	50
53	5300 ELECTROCARDIOLOGY	41256	60322	101578		101578	-53023	48555	53
55	5500 MEDICAL SUPPLIES CHARGED TO PAT				423092	423092		423092	55
56	5600 DRUGS CHARGED TO PATIENTS				25336	25336		25336	56
OUTPATIENT SERVICE COST CENTERS									
60.01	6001 SALEM MEDICAL CLINIC								60.01
61	6100 EMERGENCY	595775	1277966	1873741	-184212	1689529	-678379	1011150	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 PHOTOS RHC	246581	27578	274159	184212	458371		458371	63.50
63.60	6320 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS									
69.10	6910 CMHC								69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY								69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY								69.40
71	7100 HOME HEALTH AGENCY	206499	72294	278793	-423	278370		278370	71
SPECIAL PURPOSE COST CENTERS									
85.01	8510 PANCREAS ACQUISITION								85.01
85.02	8520 INTESTINAL ACQUISITION								85.02
85.03	8530 ISLET CELL ACQUISITION								85.03
95	SUBTOTALS	6576482	12013301	18589783		18589783	-2803369	15786414	95
NONREIMBURSABLE COST CENTERS									
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN								96
98	9800 PHYSICIANS' PRIVATE OFFICES	18169	4812	22981		22981		22981	98
98.01	9801 SALEM MEDICAL CENTER								98.01
98.02	9802 WHITAKER BLDG								98.02
101	TOTAL	6594651	12018113	18612764		18612764	-2803369	15809395	101

RECLASSIFICATIONS

1	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----				
			COST CENTER	LINE #	SALARY	OTHER	
2			2	3	4	5	
1	TO RECLASS CAFETERIA COST	A	CAFETERIA	12	171781	244799	1
2	TO RECLASS SUPPLY COST	B	MEDICAL SUPPLIES CHARGED TO P	55	9016	414076	2
3	TO RECLASS RENTALS	C	NEW CAP REL COSTS-MVBLE EQUIP	4		347146	3
4		C					4
5		C					5
6		C					6
7		C					7
8		C					8
9		C					9
10		C					10
11		C					11
12		C					12
13	TO RECLASS CRNA COST	D	NONPHYSICIAN ANESTHETISTS	20		393056	13
14	TO RECLASS REMAINING ANESTHESIA SUPP	E	OPERATING ROOM	37		55631	14
15	TO RECLASS PHYSICIAN PORTION FOR RHC	G	PHOTOS RHC	63.50		154962	15
16	TO RECLASS OTHER CAPITAL COSTS	H	NEW CAP REL COSTS-BLDG & FIXT	3		51977	16
17	TO RECLASS RESP DRUGS CHGD TO PT	I	DRUGS CHARGED TO PATIENTS	56		25336	17
18	TO RECLASS ADMIN EXPENSES FOR RHC	J	PHOTOS RHC	63.50		29250	18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36	TOTAL RECLASSIFICATIONS				180797	1716233	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
	1	6	7	8	9	10
1 TO RECLASS CAFETERIA COST	A	DIETARY	11	171781	244799	1
2 TO RECLASS SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	15.02	9016	414076	2
3 TO RECLASS RENTALS	C	ADULTS & PEDIATRICS	25		1044	10 3
4	C	HOME HEALTH AGENCY	71		423	4
5	C	OPERATING ROOM	37		127735	5
6	C	DIETARY	11		798	6
7	C	CENTRAL SERVICES & SUPPLY	15.02		13	7
8	C	LABORATORY	44		100	8
9	C	RADIOLOGY-DIAGNOSTIC	41		193828	9
10	C	RESPIRATORY THERAPY	49		11993	10
11	C	OPERATION OF PLANT	8		1697	11
12	C	ADMINISTRATIVE & ACCOUNTING	6.01		9515	12
13 TO RECLASS CRNA COST	D	ANESTHESIOLOGY	40		393056	13
14 TO RECLASS REMAINING ANESTHESIA S E	E	ANESTHESIOLOGY	40		55631	14
15 TO RECLASS PHYSICIAN PORTION FOR	G	EMERGENCY	61		154962	15
16 TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	6.01		51977	14 16
17 TO RECLASS RESP DRUGS CHGD TO PT	I	RESPIRATORY THERAPY	49		25336	17
18 TO RECLASS ADMIN EXPENSES FOR RHC	J	EMERGENCY	61		29250	18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				180797	1716233	36

ANALYSIS OF CHANGES DURING COST REPORTING  
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL  
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED  
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7  
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND								1
2 LAND IMPROVEMENTS								2
3 BUILDINGS AND FIXTURES								3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT								5
6 MOVABLE EQUIPMENT								6
7 SUBTOTAL								7
8 RECONCILING ITEMS								8
9 TOTAL								9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING BALANCES 1	----- ACQUISITIONS -----			DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7	
		PURCHASE 2	DONATION 3	TOTAL 4				
1 LAND	88638				27476	61162		1
2 LAND IMPROVEMENTS	784966	105929		105929	62549	828346		2
3 BUILDINGS AND FIXTURES	10555220	1198710		1198710	996328	10757602		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	1484547	34186		34186	5743	1512990		5
6 MOVABLE EQUIPMENT	6757655	560706		560706	199870	7118491		6
7 SUBTOTAL	19671026	1899531		1899531	1291966	20278591		7
8 RECONCILING ITEMS								8
9 TOTAL	19671026	1899531		1899531	1291966	20278591		9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	
	1	2	3	4	5	6	7	
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT				.000000				3
4 NEW CAP REL COSTS-MVBLE EQUIP				.000000				4
5 TOTAL				.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	515922					51977	567899 3
4 NEW CAP REL COSTS-MVBLE EQUIP	728989	347146				-439	1075696 4
5 TOTAL	1244911	347146				51538	1643595 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL						
	DEPREC-IATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT	515922						515922 3
4 NEW CAP REL COSTS-MVBLE EQUIP	728989						728989 4
5 TOTAL	1244911						1244911 5

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF
			COST CENTER	LINE NO.	
	1	2	3	4	5
1 INVESTMENT INCOME-OLD BLDGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-NEW BLDGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	3
4 INVESTMENT INCOME-NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5 INVESTMENT INCOME-OTHER	B	-165005	ADMINISTRATIVE & ACCOUNTING	6.01	5
6 TRADE, QUANTITY, AND TIME DISCOUNTS					6
7 REFUNDS AND REBATES OF EXPENSES					7
8 RENTAL OF PROVIDER SPACE BY SUPPLIERS					8
9 TELEPHONE SERVICES (PAY STATIONS EXCL)	A	-1284	ADMINISTRATIVE & ACCOUNTING	6.01	9
10 TELEVISION AND RADIO SERVICE	A	-439	NEW CAP REL COSTS-MVBLE EQUIP	4	14 10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-827515			12
13 SALE OF SCRAP, WASTE, ETC.					13
14 RELATED ORGANIZATION TRANSACTIONS	WKST A-8-1				14
15 LAUNDRY AND LINEN SERVICE					15
16 CAFETERIA - EMPLOYEES AND GUESTS	B	-99755	CAFETERIA	12	16
17 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					17
18 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					18
19 SALE OF DRUGS TO OTHER THAN PATIENTS					19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-183	MEDICAL RECORDS & LIBRARY	17	20
21 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					21
22 VENDING MACHINES					22
23 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES					23
24 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					24
25 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		RESPIRATORY THERAPY	49	25
26 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		PHYSICAL THERAPY	50	26
27 ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST A-8-3		HOME HEALTH AGENCY	71	27
28 UTIL REVIEW-PHYSICIANS' COMPENSATION			UTILIZATION REVIEW-SNF	89	28
29 DEPRECIATION--OLD BUILDINGS & FIXTURES			OLD CAP REL COSTS-BLDG & FIXT	1	29
30 DEPRECIATION--OLD MOVABLE EQUIPMENT			OLD CAP REL COSTS-MVBLE EQUIP	2	30
31 DEPRECIATION--NEW BUILDINGS & FIXTURES			NEW CAP REL COSTS-BLDG & FIXT	3	31
32 DEPRECIATION--NEW MOVABLE EQUIPMENT			NEW CAP REL COSTS-MVBLE EQUIP	4	32
33 NON-PHYSICIAN ANESTHETIST	A	-393056	NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4				35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4				36
37 PROVISION FOR BAD DEBTS	A	-1152525	ADMINISTRATIVE & ACCOUNTING	6.01	37
38 DIETARY REVENUE	B	-23011	DIETARY	11	38
39 BUS OFFICE COSTS ASSOC W/ PHYS CH	A	-28622	BUSINESS SERVICES	6.02	39
40					40
41 PHYSICIAN RECRUITMENT	A	-52118	ADMINISTRATIVE & ACCOUNTING	6.01	41
42 OTHER REVENUE	B	-1607	ADMINISTRATIVE & ACCOUNTING	6.01	42
43 LOBBYING PORTION OF DUES	A	-12528	ADMINISTRATIVE & ACCOUNTING	6.01	43
44 MARKETING	A	-45014	EMPLOYEE BENEFITS	5	44
45 OTHER REVENUE	B	-707	ADMINISTRATIVE & ACCOUNTING	6.01	45
46					46
47					47
48					48
49					49
50 TOTAL		-2803369			50

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJUSTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS					5

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

THE SECRETARY, BY VIRTUE OF 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.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES 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	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----				
		PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
5						5

- (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:

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2008.05  
 08/14/2008 08:54

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 37	OPERATING ROOM	43555	43555					
2 44	LABORATORY	52500		52500				
3 49	RESPIRATORY THERAPY	51808	51808					
4 49	RESPIRATORY THERAPY	750	750					
5 53	ELECTROCARDIOLOGY	53023	53023					
6 61	EMERGENCY	1013121	678379	334742				
101	TOTAL	1214757	827515	387242				



COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP	NEW CAP	NEW CAP	EMPLOYEE	SUBTOTAL	ADMINISTRA	BUSINESS S	OPERATION	
	FOR COST	BLDGS &	MOVABLE	BENEFITS		TIVE & ACC	ERVICES	OF PLANT	
	ALLOCATION	FIXTURES	EQUIPMENT			OUNTING			
	0	3	4	5	5A	6.01	6.02	8	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	567899	567899							3
4 NEW CAP REL COSTS-MVBLE EQUIP	1075696		1075696						4
5 EMPLOYEE BENEFITS	1742584			1742584					5
6.01 ADMINISTRATIVE & ACCOUNTING	952299	115603	10988	105153	1184043	1184043			6.01
6.02 BUSINESS SERVICES	735394	39092	110912	129413	1014811	82157	1096968		6.02
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	725370	38396	6214	46272	816252	66082		882334	8
9 LAUNDRY & LINEN SERVICE	56558	6733	2783	8635	74709	6048		15727	9
10 HOUSEKEEPING	212412	5869	539	39688	258508	20928		13707	10
11 DIETARY	116461	23559	5894	15443	161357	13063		57314	11
12 CAFETERIA	316825			45864	362689	29363			12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	126181	9121	163	29104	164569	13323		21303	14
15 CENTRAL SERVICES & SUPPLY									15
15.01 PURCHASING	89441	10253	538	20042	120274	9737		23948	15.01
15.02 CENTRAL SERVICES & SUPPLY	17216	7346	643	100	25305	2049		17157	15.02
16 PHARMACY	840958	5953	383	11329	858623	69512		13940	16
17 MEDICAL RECORDS & LIBRARY	317194	24761	12714	64146	418815	33906		57832	17
18 SOCIAL SERVICE	45901			11069	56970	4612			18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	1574058	58696	35119	378543	2046416	165678	73419	139452	25
26 INTENSIVE CARE UNIT									26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	764064	57326	198798	193868	1214056	98288	63205	133893	37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC	1096016	39452	561434	155080	1851982	149933	326981	92145	41
44 LABORATORY	1240930	18884	63553	127270	1450637	117441	261808	44107	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	345259	14377	25492	63254	448382	36300	39636	33992	49
50 PHYSICAL THERAPY	582824	27829	5706	616359	498999	49241	49241	66822	50
53 ELECTROCARDIOLOGY	48555		7395	11015	66965	5421	17507		53
55 MEDICAL SUPPLIES CHARGED TO PAT	423092			2407	425499	34448	99935		55
56 DRUGS CHARGED TO PATIENTS	25336				25336	2051	72046		56
OUTPATIENT SERVICE COST CENTERS									
60.01 SALEM MEDICAL CLINIC									60.01
61 EMERGENCY	1011150	20262	15410	159068	1205890	97626	81796	45018	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 PHOTOS RHC	458371	6733	420	65836	531360	43018	11394	18032	63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY	278370	10100	3624	55134	347228	28111		23590	71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	15786414	540345	1068722	1737733	15747035	1178994	1096968	817979	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN		3910			3910	317		9132	96
98 PHYSICIANS' PRIVATE OFFICES	22981	23644	6940	4851	58416	4729		55223	98
98.01 SALEM MEDICAL CENTER			34		34	3			98.01
98.02 WHITAKER BLDG									98.02
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	15809395	567899	1075696	1742584	15809395	1184043	1096968	882334	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY
	9	10	11	12	14	15.01	15.02	16
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6.01 ADMINISTRATIVE & ACCOUNTING								6.01
6.02 BUSINESS SERVICES								6.02
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE	96484							9
10 HOUSEKEEPING	2840	295983						10
11 DIETARY	1172	18872	251778					11
12 CAFETERIA				392052				12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION				6384	205579			14
15 CENTRAL SERVICES & SUPPLY								15
15.01 PURCHASING				6614		160573		15.01
15.02 CENTRAL SERVICES & SUPPLY	407	12183		1909		595	59605	15.02
16 PHARMACY		5017		5430		415		952937 16
17 MEDICAL RECORDS & LIBRARY		1672		29452		1129		17
18 SOCIAL SERVICE				2764		33		18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	55250	109172	251778	111719	93897	8448		25
26 INTENSIVE CARE UNIT								26
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	12083	27233		37744	51923	14661	85	37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC	8213	21500		45477		26576		41
44 LABORATORY		19589		41232		91309		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY		4300		24351		6303		49
50 PHYSICAL THERAPY	5317	15050				1216	304	50
53 ELECTROCARDIOLOGY		3106				643		53
55 MEDICAL SUPPLIES CHARGED TO PAT							58945	55
56 DRUGS CHARGED TO PATIENTS								952937 56
OUTPATIENT SERVICE COST CENTERS								
60.01 SALEM MEDICAL CLINIC								60.01
61 EMERGENCY	11202	35356		45609	44556	7462		61
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 PHOTOS RHC		3822		15894	15203	554		63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY		4778		15466		790	271	71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	96484	281650	251778	390045	205579	160134	59605	952937 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN								96
98 PHYSICIANS' PRIVATE OFFICES		14333		2007		439		98
98.01 SALEM MEDICAL CENTER								98.01
98.02 WHITAKER BLDG								98.02
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	96484	295983	251778	392052	205579	160573	59605	952937 103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY 17	SOCIAL SERVICE 18	SUBTOTAL 25	I&R COST & POST STEP-DOWN ADJS 26	TOTAL 27	
GENERAL SERVICE COST CENTERS						
1 OLD CAP REL COSTS-BLDG & FIXT						1
2 OLD CAP REL COSTS-MVBLE EQUIP						2
3 NEW CAP REL COSTS-BLDG & FIXT						3
4 NEW CAP REL COSTS-MVBLE EQUIP						4
5 EMPLOYEE BENEFITS						5
6.01 ADMINISTRATIVE & ACCOUNTING						6.01
6.02 BUSINESS SERVICES						6.02
7 MAINTENANCE & REPAIRS						7
8 OPERATION OF PLANT						8
9 LAUNDRY & LINEN SERVICE						9
10 HOUSEKEEPING						10
11 DIETARY						11
12 CAFETERIA						12
13 MAINTENANCE OF PERSONNEL						13
14 NURSING ADMINISTRATION						14
15 CENTRAL SERVICES & SUPPLY						15
15.01 PURCHASING						15.01
15.02 CENTRAL SERVICES & SUPPLY						15.02
16 PHARMACY						16
17 MEDICAL RECORDS & LIBRARY	542806					17
18 SOCIAL SERVICE		64379				18
20 NONPHYSICIAN ANESTHETISTS						20
21 NURSING SCHOOL						21
22 I&R SERVICES-SALARY & FRINGES A						22
23 I&R SERVICES-OTHER PRGM COSTS A						23
24 PARAMED ED PRGM-(SPECIFY)						24
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	245690	64379	3365298		3365298	25
26 INTENSIVE CARE UNIT						26
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	24594		1677765		1677765	37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	78502		2601309		2601309	41
44 LABORATORY	105829		2131952		2131952	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO						46.30
49 RESPIRATORY THERAPY	13663		606927		606927	49
50 PHYSICAL THERAPY	22855		827063		827063	50
53 ELECTROCARDIOLOGY	7453		101095		101095	53
55 MEDICAL SUPPLIES CHARGED TO PAT			618827		618827	55
56 DRUGS CHARGED TO PATIENTS			1052370		1052370	56
OUTPATIENT SERVICE COST CENTERS						
60.01 SALEM MEDICAL CLINIC						60.01
61 EMERGENCY	38506		1613021		1613021	61
62 OBSERVATION BEDS (NON-DISTINCT						62
63.50 PHOTOS RHC	5714		644991		644991	63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
69.10 CMHC						69.10
69.20 OUTPATIENT PHYSICAL THERAPY						69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY						69.30
69.40 OUTPATIENT SPEECH PATHOLOGY						69.40
71 HOME HEALTH AGENCY			420234		420234	71
SPECIAL PURPOSE COST CENTERS						
85.01 PANCREAS ACQUISITION						85.01
85.02 INTESTINAL ACQUISITION						85.02
85.03 ISLET CELL ACQUISITION						85.03
95 SUBTOTALS	542806	64379	15660852		15660852	95
NONREIMBURSABLE COST CENTERS						
96 GIFT, FLOWER, COFFEE SHOP & CAN			13359		13359	96
98 PHYSICIANS' PRIVATE OFFICES			135147		135147	98
98.01 SALEM MEDICAL CENTER			37		37	98.01
98.02 WHITAKER BLDG						98.02
101 CROSS FOOT ADJUSTMENTS						101
102 NEGATIVE COST CENTER						102
103 TOTAL	542806	64379	15809395		15809395	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	NEW CAP BLDGS & FIXTURES 3	NEW CAP MOVABLE EQUIPMENT 4	CAP REL COST TO BE ALLOC 4A	ADMINISTRA TIVE & ACC OUNTING 6.01	BUSINESS S ERVICES 6.02	S OPERATIO N OF PLANT 8	LAUNDRY & LINEN SERVICE 9
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6.01 ADMINISTRATIVE & ACCOUNTING		115603	10988	126591	126591			6.01
6.02 BUSINESS SERVICES		39092	110912	150004	8784	158788		6.02
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT		38396	6214	44610	7065		51675	8
9 LAUNDRY & LINEN SERVICE		6733	2783	9516	647		921	11084 9
10 HOUSEKEEPING		5869	539	6408	2238		803	326 10
11 DIETARY		23559	5894	29453	1397		3357	135 11
12 CAFETERIA					3139			12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION		9121	163	9284	1425		1248	14
15 CENTRAL SERVICES & SUPPLY								15
15.01 PURCHASING		10253	538	10791	1041		1403	15.01
15.02 CENTRAL SERVICES & SUPPLY		7346	643	7989	219		1005	47 15.02
16 PHARMACY		5953	383	6336	7432		816	16
17 MEDICAL RECORDS & LIBRARY		24761	12714	37475	3625		3387	17
18 SOCIAL SERVICE					493			18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS		58696	35119	93815	17708	10628	8165	6347 25
26 INTENSIVE CARE UNIT								26
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		57326	198798	256124	10509	9150	7842	1388 37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC		39452	561434	600886	16031	47326	5397	943 41
44 LABORATORY		18884	63553	82437	12557	37899	2583	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY		14377	25492	39869	3881	5738	1991	49
50 PHYSICAL THERAPY		27829	5706	33535	5335	7128	3913	611 50
53 ELECTROCARDIOLOGY			7395	7395	580	2534		53
55 MEDICAL SUPPLIES CHARGED TO PAT					3683	14466		55
56 DRUGS CHARGED TO PATIENTS					219	10429		56
OUTPATIENT SERVICE COST CENTERS								
60.01 SALEM MEDICAL CLINIC								60.01
61 EMERGENCY		20262	15410	35672	10438	11841	2637	1287 61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 PHOTOS RHC		6733	420	7153	4599	1649	1056	63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY		10100	3624	13724	3006		1382	71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS		540345	1068722	1609067	126051	158788	47906	11084 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN		3910		3910	34		535	96
98 PHYSICIANS' PRIVATE OFFICES		23644	6940	30584	506		3234	98
98.01 SALEM MEDICAL CENTER			34	34				98.01
98.02 WHITAKER BLDG								98.02
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL		567899	1075696	1643595	126591	158788	51675	11084 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY
	10	11	12	14	15.01	15.02	16	17
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6.01 ADMINISTRATIVE & ACCOUNTING								6.01
6.02 BUSINESS SERVICES								6.02
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING	9775							10
11 DIETARY	623	34965						11
12 CAFETERIA			3139					12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION			51	12008				14
15 CENTRAL SERVICES & SUPPLY								15
15.01 PURCHASING			53		13288			15.01
15.02 CENTRAL SERVICES & SUPPLY	402		15		49	9726		15.02
16 PHARMACY	166		43		34		14827	16
17 MEDICAL RECORDS & LIBRARY	55		236		93			44871 17
18 SOCIAL SERVICE			22		3			18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	3606	34965	896	5484	699			20312 25
26 INTENSIVE CARE UNIT								26
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	899		302	3033	1213	14		2033 37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC	710		364		2199			6489 41
44 LABORATORY	647		330		7557			8748 44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY	142		195		522			1129 49
50 PHYSICAL THERAPY	497				101	50		1889 50
53 ELECTROCARDIOLOGY	103				53			616 53
55 MEDICAL SUPPLIES CHARGED TO PAT						9618		55
56 DRUGS CHARGED TO PATIENTS							14827	56
OUTPATIENT SERVICE COST CENTERS								
60.01 SALEM MEDICAL CLINIC								60.01
61 EMERGENCY	1168		365	2603	618			3183 61
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 PHOTOS RHC	126		127	888	46			472 63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY	158		124		65	44		71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	9302	34965	3123	12008	13252	9726	14827	44871 95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN								96
98 PHYSICIANS' PRIVATE OFFICES	473		16		36			98
98.01 SALEM MEDICAL CENTER								98.01
98.02 WHITAKER BLDG								98.02
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	9775	34965	3139	12008	13288	9726	14827	44871 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL
	18	25	26	27
GENERAL SERVICE COST CENTERS				
1 OLD CAP REL COSTS-BLDG & FIXT				1
2 OLD CAP REL COSTS-MVBLE EQUIP				2
3 NEW CAP REL COSTS-BLDG & FIXT				3
4 NEW CAP REL COSTS-MVBLE EQUIP				4
5 EMPLOYEE BENEFITS				5
6.01 ADMINISTRATIVE & ACCOUNTING				6.01
6.02 BUSINESS SERVICES				6.02
7 MAINTENANCE & REPAIRS				7
8 OPERATION OF PLANT				8
9 LAUNDRY & LINEN SERVICE				9
10 HOUSEKEEPING				10
11 DIETARY				11
12 CAFETERIA				12
13 MAINTENANCE OF PERSONNEL				13
14 NURSING ADMINISTRATION				14
15 CENTRAL SERVICES & SUPPLY				15
15.01 PURCHASING				15.01
15.02 CENTRAL SERVICES & SUPPLY				15.02
16 PHARMACY				16
17 MEDICAL RECORDS & LIBRARY				17
18 SOCIAL SERVICE	518			18
20 NONPHYSICIAN ANESTHETISTS				20
21 NURSING SCHOOL				21
22 I&R SERVICES-SALARY & FRINGES A				22
23 I&R SERVICES-OTHER PRGM COSTS A				23
24 PARAMED ED PRGM-(SPECIFY)				24
INPATIENT ROUTINE SERV COST CENTERS				
25 ADULTS & PEDIATRICS	518	203143		203143
26 INTENSIVE CARE UNIT				26
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM		292507		292507
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC		680345		680345
44 LABORATORY		152758		152758
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY		53467		53467
50 PHYSICAL THERAPY		53059		53059
53 ELECTROCARDIOLOGY		11281		11281
55 MEDICAL SUPPLIES CHARGED TO PAT		27767		27767
56 DRUGS CHARGED TO PATIENTS		25475		25475
OUTPATIENT SERVICE COST CENTERS				
60.01 SALEM MEDICAL CLINIC				60.01
61 EMERGENCY		69812		69812
62 OBSERVATION BEDS (NON-DISTINCT)				62
63.50 PHOTOS RHC		16116		16116
63.60 FQHC				63.60
OTHER REIMBURSABLE COST CENTERS				
69.10 CMHC				69.10
69.20 OUTPATIENT PHYSICAL THERAPY				69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY				69.30
69.40 OUTPATIENT SPEECH PATHOLOGY				69.40
71 HOME HEALTH AGENCY		18503		18503
SPECIAL PURPOSE COST CENTERS				
85.01 PANCREAS ACQUISITION				85.01
85.02 INTESTINAL ACQUISITION				85.02
85.03 ISLET CELL ACQUISITION				85.03
95 SUBTOTALS	518	1604233		1604233
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & CAN		4479		4479
98 PHYSICIANS' PRIVATE OFFICES		34849		34849
98.01 SALEM MEDICAL CENTER		34		34
98.02 WHITAKER BLDG				98.01
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 TOTAL	518	1643595		1643595



COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP	NEW CAP	EMPLOYEE	RECON- CILIATION	ADMINISTRA	BUSINESS S	OPERATION	
	BLDGS & FIXTURES SQUARE FEET	MOVABLE EQUIPMENT DOLLAR VALUE	BENEFITS GROSS SALARIES		TIVE & ACC OUNTING ACCUM COST	ERVICES	CHAR GES	
	3	4	5	6A.01	6.01	6.02	8	
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	567899	1075696	1742584		1184043	1096968	882334	103
104 UNIT COST MULT-WS B PT I		.999592				.033193		104
104 UNIT COST MULT-WS B PT I	7.651666		.266994		.080958		17.871504	104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III					126591	158788	51675	107
108 UNIT COST MULT-WS B PT III						.004805		108
108 UNIT COST MULT-WS B PT III					.008656		1.046667	108



COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS-TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY
	POUNDS OF LAUNDRY 9	HOURS OF SERVICE 10	MEALS SERVED 11	MEALS SERVED 12	DIRECT NRSING HRS 14	COSTED REQUIS. 15.01	COSTED REQ UIS. 15.02	COSTED REQUIS. 16
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	96484	295983	251778	392052	205579	160573	59605	952937 103
104 UNIT COST MULT-WS B PT I	5.504564		27.683123		1.547895		.142166	104
104 UNIT COST MULT-WS B PT I		238.888620		32.906832		.184688		9529.370000 104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III	11084	9775	34965	3139	12008	13288	9726	14827 107
108 UNIT COST MULT-WS B PT III	.632360		3.844420		.090414		.023198	108
108 UNIT COST MULT-WS B PT III		7.889427		.263472		.015284		148.270000 108

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL	SOCIAL	
	RECORDS & LIBRARY TIME SPENT	SERVICE TIME SPENT	
	17	18	
GENERAL SERVICE COST CENTERS			
1 OLD CAP REL COSTS-BLDG & FIXT			1
2 OLD CAP REL COSTS-MVBLE EQUIP			2
3 NEW CAP REL COSTS-BLDG & FIXT			3
4 NEW CAP REL COSTS-MVBLE EQUIP			4
5 EMPLOYEE BENEFITS			5
6.01 ADMINISTRATIVE & ACCOUNTING			6.01
6.02 BUSINESS SERVICES			6.02
7 MAINTENANCE & REPAIRS			7
8 OPERATION OF PLANT			8
9 LAUNDRY & LINEN SERVICE			9
10 HOUSEKEEPING			10
11 DIETARY			11
12 CAFETERIA			12
13 MAINTENANCE OF PERSONNEL			13
14 NURSING ADMINISTRATION			14
15 CENTRAL SERVICES & SUPPLY			15
15.01 PURCHASING			15.01
15.02 CENTRAL SERVICES & SUPPLY			15.02
16 PHARMACY			16
17 MEDICAL RECORDS & LIBRARY	2185		17
18 SOCIAL SERVICE		3629	18
20 NONPHYSICIAN ANESTHETISTS			20
21 NURSING SCHOOL			21
22 I&R SERVICES-SALARY & FRINGES			22
23 I&R SERVICES-OTHER PRGM COSTS			23
24 PARAMED ED PRGM-(SPECIFY)			24
INPATIENT ROUTINE SERV COST CENTERS			
25 ADULTS & PEDIATRICS	989	3629	25
26 INTENSIVE CARE UNIT			26
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	99		37
40 ANESTHESIOLOGY			40
41 RADIOLOGY-DIAGNOSTIC	316		41
44 LABORATORY	426		44
46.30 BLOOD CLOTTING FACTORS ADMIN			46.30
49 RESPIRATORY THERAPY	55		49
50 PHYSICAL THERAPY	92		50
53 ELECTROCARDIOLOGY	30		53
55 MEDICAL SUPPLIES CHARGED TO P			55
56 DRUGS CHARGED TO PATIENTS			56
OUTPATIENT SERVICE COST CENTERS			
60.01 SALEM MEDICAL CLINIC			60.01
61 EMERGENCY	155		61
62 OBSERVATION BEDS (NON-DISTINC			62
63.50 PHOTOS RHC	23		63.50
63.60 FQHC			63.60
OTHER REIMBURSABLE COST CENTERS			
69.10 CMHC			69.10
69.20 OUTPATIENT PHYSICAL THERAPY			69.20
69.30 OUTPATIENT OCCUPATIONAL THERA			69.30
69.40 OUTPATIENT SPEECH PATHOLOGY			69.40
71 HOME HEALTH AGENCY			71
SPECIAL PURPOSE COST CENTERS			
85.01 PANCREAS ACQUISITION			85.01
85.02 INTESTINAL ACQUISITION			85.02
85.03 ISLET CELL ACQUISITION			85.03
95 SUBTOTALS	2185	3629	95
NONREIMBURSABLE COST CENTERS			
96 GIFT, FLOWER, COFFEE SHOP & C			96
98 PHYSICIANS' PRIVATE OFFICES			98
98.01 SALEM MEDICAL CENTER			98.01
98.02 WHITAKER BLDG			98.02

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL	SOCIAL	
	RECORDS & LIBRARY TIME SPENT	SERVICE TIME SPENT	
	17	18	
101 CROSS FOOT ADJUSTMENTS			101
102 NEGATIVE COST CENTER			102
103 COST TO BE ALLOC PER B PT I	542806	64379	103
104 UNIT COST MULT-WS B PT I	248.423799		104
104 UNIT COST MULT-WS B PT I		17.740149	104
105 COST TO BE ALLOC PER B PT II			105
106 UNIT COST MULT-WS B PT II			106
106 UNIT COST MULT-WS B PT II			106
107 COST TO BE ALLOC PER B PT III	44871	518	107
108 UNIT COST MULT-WS B PT III	20.535927		108
108 UNIT COST MULT-WS B PT III		.142739	108

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
25 INPATIENT ROUTINE SERV COST CENTERS						25
25 ADULTS & PEDIATRICS	3365298		3365298		3365298	25
26 INTENSIVE CARE UNIT						26
26 ANCILLARY SERVICE COST CENTERS						26
37 OPERATING ROOM	1677765		1677765		1677765	37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	2601309		2601309		2601309	41
44 LABORATORY	2131952		2131952		2131952	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	606927		606927		606927	49
50 PHYSICAL THERAPY	827063		827063		827063	50
53 ELECTROCARDIOLOGY	101095		101095		101095	53
55 MEDICAL SUPPLIES CHARGED TO	618827		618827		618827	55
56 DRUGS CHARGED TO PATIENTS	1052370		1052370		1052370	56
60.01 OUTPATIENT SERVICE COST CENTERS						60.01
60.01 SALEM MEDICAL CLINIC						60.01
61 EMERGENCY	1613021		1613021		1613021	61
62 OBSERVATION BEDS (NON-DISTI	139787		139787		139787	62
63.50 PHOTOS RHC	644991		644991		644991	63.50
63.60 FQHC						63.60
63.60 OTHER REIMBURSABLE COST CENTERS						63.60
101 SUBTOTAL	15380405		15380405		15380405	101
102 LESS OBSERVATION BEDS	139787		139787		139787	102
103 TOTAL	15240618		15240618		15240618	103

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25 INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	2211894		2211894			25
26 INTENSIVE CARE UNIT						26
26 ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	412427	1491745	1904172	.881100	.881100	.881100 37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	1036147	8814783	9850930	.264067	.264067	.264067 41
44 LABORATORY	1492268	6395167	7887435	.270297	.270297	.270297 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	364096	830015	1194111	.508267	.508267	.508267 49
50 PHYSICAL THERAPY	99890	1383572	1483462	.557522	.557522	.557522 50
53 ELECTROCARDIOLOGY	67336	460103	527439	.191671	.191671	.191671 53
55 MEDICAL SUPPLIES CHARGED TO	1296304	1714413	3010717	.205541	.205541	.205541 55
56 DRUGS CHARGED TO PATIENTS	1153520	1016990	2170510	.484849	.484849	.484849 56
56 OUTPATIENT SERVICE COST CENTERS						
60.01 SALEM MEDICAL CLINIC						60.01
61 EMERGENCY	112705	2351542	2464247	.654570	.654570	.654570 61
62 OBSERVATION BEDS (NON-DISTI	2000	62616	64616	2.163350	2.163350	2.163350 62
63.50 PHOTOS RHC		343273	343273	1.878945	1.878945	1.878945 63.50
63.60 FQHC						63.60
63.60 OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	8248587	24864219	33112806			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	8248587	24864219	33112806			103

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1345) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WORKSHEET C,			PROGRAM CHARGES			
	PART II	PART I	PART II	OUTPATIENT	OUTPATIENT	OTHER	
	COL. 8	COL. 9	COL. 9	AMBULATORY	RADIOLOGY	OUTPATIENT	
	1	1.01	1.02	SURGICAL	CENTER	DIAGNOSTIC	
				2	3	4	
37 ANCILLARY SERVICE COST CENTERS							37
40 OPERATING ROOM	.881100	.881100	.881100				40
41 ANESTHESIOLOGY							41
44 RADIOLOGY-DIAGNOSTIC	.264067	.264067	.264067				44
44 LABORATORY	.270297	.270297	.270297				44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	.508267	.508267	.508267				49
50 PHYSICAL THERAPY	.557522	.557522	.557522				50
53 ELECTROCARDIOLOGY	.191671	.191671	.191671				53
55 MEDICAL SUPPLIES CHARGED TO PAT	.205541	.205541	.205541				55
56 DRUGS CHARGED TO PATIENTS	.484849	.484849	.484849				56
OUTPATIENT SERVICE COST CENTERS							
60.01 SALEM MEDICAL CLINIC							60.01
61 EMERGENCY	.654570	.654570	.654570				61
62 OBSERVATION BEDS (NON-DISTINCT	2.163350	2.163350	2.163350				62
63.50 PHOTOS RHC	1.878945	1.878945	1.878945				63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL							101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES							104

PART VI - VACCINE COST APPORTIONMENT

1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES	1	.484849	1
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)	2		
2.01 VACCINE CHARGES - HEPATITIS B	2.01		2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)	3		
3.01 VACCINE COSTS - HEPATITIS B	3.01		3.01

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1345) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES					PROGRAM COST		
	ALL OTHER (1) (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	ALL OTHER (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	PPS SER- VICES (SEE INSTRU.)	OUTPATIENT AMBULATORY SURGICAL CENTER	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	5	5.01	5.02	5.03	5.04	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	699315							37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC	3617056							41
44 LABORATORY	2317598							44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY	366991							49
50 PHYSICAL THERAPY	507159							50
53 ELECTROCARDIOLOGY	291760							53
55 MEDICAL SUPPLIES CHARGED TO PA	785023							55
56 DRUGS CHARGED TO PATIENTS	534664							56
OUTPATIENT SERVICE COST CENTERS								
60.01 SALEM MEDICAL CLINIC								60.01
61 EMERGENCY	897545							61
62 OBSERVATION BEDS (NON-DISTINCT	41094							62
63.50 PHOTOS RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
65.01 AMBULANCE SERVICES (2ND PERIOD								65.01
65.02 AMBULANCE SERVICES (3RD PERIOD								65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56								65.03
101 SUBTOTAL	10058205							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	10058205							104

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

WORKSHEET D  
 PARTS V & VI

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1345) [ ] SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] SUB I [ ] NF  
 BOXES [ ] TITLE XIX - O/P [ ] SUB II [ ] S/B-SNF  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM COST				HOSPITAL	HOSPITAL	
	ALL OTHER (COLS 1x5)	PPS SERVICES (COLUMNS 1.01x5.01)	ALL OTHER (COLUMNS 1.01x5.02)	PPS SERVICES (COLUMNS 1.01x5.03)	PPS SERVICES (COLUMNS 1.01x5.04)	I/P PART B CHARGES (SEE INSTRU.)	I/P PART B COST (COLUMNS 1.02x10)
	9	9.01	9.02	9.03	9.04	10	11
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	616166						37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	955145						41
44 LABORATORY	626440						44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	186529						49
50 PHYSICAL THERAPY	282752						50
53 ELECTROCARDIOLOGY	55922						53
55 MEDICAL SUPPLIES CHARGED TO PAT	161354						55
56 DRUGS CHARGED TO PATIENTS	259231						56
OUTPATIENT SERVICE COST CENTERS							
60.01 SALEM MEDICAL CLINIC							60.01
61 EMERGENCY	587506						61
62 OBSERVATION BEDS (NON-DISTINCT	88901						62
63.50 PHOTOS RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
65.01 AMBULANCE SERVICES (2ND PERIOD)							65.01
65.02 AMBULANCE SERVICES (3RD PERIOD)							65.02
65.03 AMBULANCE CHARGES (S-2 LINE 56.							65.03
101 SUBTOTAL	3819946						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	3819946						104

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	
	1	2	3	4	5	6	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS				203143	12096	191047	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 I							31
33 NURSERY							33
101 TOTAL				203143		191047	101

COST CENTER DESCRIPTION	OLD CAPITAL			NEW CAPITAL			
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST	
	7	8	9	10	11	12	
INPAT ROUTINE SERV COST CTRS							
25 ADULTS & PEDIATRICS	3532	240			54.09	12982	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 I							31
33 NURSERY							33
101 TOTAL	3532	240				12982	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (14-1345) [ ] SUB III [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SUB IV [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [XX] OTHER

COST CENTER DESCRIPTION	OLD	NEW	TOTAL	INPATIENT	----	----	RATIO OF	RATIO OF	CAPITAL	CAPITAL
	CAPITAL	CAPITAL			OLD CAPITAL	NEW CAPITAL				
	RELATED	RELATED	CHARGES	PROGRAM	CHARGES	COSTS	CHARGES	CHARGES	COSTS	COSTS
	COST	COST	3	CHARGES	4	5	6	7	8	
	1	2								
ANCILLARY SERVICE COST CENTERS										
37 OPERATING ROOM		292507	1904172	39660			.153614		6092	37
40 ANESTHESIOLOGY										40
41 RADIOLOGY-DIAGNOSTIC		680345	9850930	97400			.069064		6727	41
44 LABORATORY		152758	7887435	129799			.019367		2514	44
46.30 BLOOD CLOTTING FACTORS ADMIN										46.30
49 RESPIRATORY THERAPY		53467	1194111	41336			.044776		1851	49
50 PHYSICAL THERAPY		53059	1483462	3170			.035767		113	50
53 ELECTROCARDIOLOGY		11281	527439	5520			.021388		118	53
55 MEDICAL SUPPLIES CHARGED TO P		27767	3010717	64839			.009223		598	55
56 DRUGS CHARGED TO PATIENTS		25475	2170510	118810			.011737		1394	56
OUTPATIENT SERVICE COST CENTERS										
60.01 SALEM MEDICAL CLINIC										60.01
61 EMERGENCY		69812	2464247	26453			.028330		749	61
62 OBSERVATION BEDS (NON-DISTINC			64616							62
63.50 PHOTOS RHC			343273							63.50
63.60 FQHC										63.60
OTHER REIMBURSABLE COST CENTERS										
101 TOTAL		1366471	30557639	526987					20156	101

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [ ] TITLE XVIII-PT A  
 BOXES [XX] TITLE XIX

COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST COST 1	MEDICAL EDUCATION COST 2	SWING-BED ADJUSTMENT AMOUNT 3	TOTAL COSTS 4	TOTAL PATIENT DAYS 5	PER DIEM 6	INPATIENT PROGRAM DAYS 7	INPATIENT PROGRAM PASS THRU COSTS 8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					3532		240	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 I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					3532		240	101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1345)	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
			[ ]	SUB III	[ ]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST	NONPHYSICIAN ANESTHETIST	MEDICAL EDUCATION				
	COST	COST	COST				
	1	1.01	2	2.01	2.02	2.03	3
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM							37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
53 ELECTROCARDIOLOGY							53
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
OUTPATIENT SERVICE COST CENTERS							
60.01 SALEM MEDICAL CLINIC							60.01
61 EMERGENCY							61
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 PHOTOS RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (14-1345) [ ] SUB IV [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] SUB II [ ] NF [ ] OTHER  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		1904172			39660		37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC		9850930			97400		41
44 LABORATORY		7887435			129799		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		1194111			41336		49
50 PHYSICAL THERAPY		1483462			3170		50
53 ELECTROCARDIOLOGY		527439			5520		53
55 MEDICAL SUPPLIES CHARGED TO P		3010717			64839		55
56 DRUGS CHARGED TO PATIENTS		2170510			118810		56
OUTPATIENT SERVICE COST CENTERS							
60.01 SALEM MEDICAL CLINIC							60.01
61 EMERGENCY		2464247			26453		61
62 OBSERVATION BEDS (NON-DISTINC		64616					62
63.50 PHOTOS RHC		343273					63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		30557639			526987		101

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1345)	[ ]	SUB IV	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	SUB I	[ ]	SNF	[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	SUB II	[ ]	NF	[ ]	OTHER
			[ ]	SUB III	[ ]	ICF/MR		

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM CHARGES	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS	OUTPATIENT PROGRAM PASS THROUGH COSTS
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60.01 SALEM MEDICAL CLINIC					60.01
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 PHOTOS RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL	8.01	8.02	9	9.01	9.02

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

[ ] TITLE V-INPT                      [XX] TITLE XVIII-PART A                      [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	SNF
INPATIENT DAYS	1	1	1	1	1	1
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3785					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3532					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3532					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	220					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	33					7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2470					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	165					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	55					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						13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)						14
15 TOTAL NURSERY DAYS						15
16 TITLE V OR XIX NURSERY DAYS						16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
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	98.28						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.28						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3365298						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3243						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	200378						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3164920						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2154000						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2154000						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.469322						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	609.85						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3164920						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	896.07					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2213293					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2213293					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	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
	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	1352351					48
49 TOTAL PROGRAM INPATIENT COSTS	3565644					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES						50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES						51
52 TOTAL PROGRAM EXCLUDABLE COST						52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
54						PROGRAM DISCHARGES
55						TARGET AMOUNT PER DISCHARGE
56						TARGET AMOUNT
57						DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58						BONUS PAYMENT
58.01						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)
59.02						PROGRAM DISCHARGES PRIOR TO JULY 1
59.03						PROGRAM DISCHARGES AFTER JULY 1
59.04						PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05						REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60	147852					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61	49284					MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
62	197136					TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65						TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

SNF

1

66	SNF/NF/ICF/MR ROUTINE SERVICE COST	66
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	67
68	PROGRAM ROUTINE SERVICE COST	68
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	69
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	70
71	CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	71
72	PER DIEM CAPITAL RELATED COSTS	72
73	PROGRAM CAPITAL RELATED COSTS	73
74	INPATIENT ROUTINE SERVICE COST	74
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	75
76	TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	76
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	77
78	INPATIENT ROUTINE SERVICE COST LIMITATION	78
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	79
80	PROGRAM INPATIENT ANCILLARY SERVICES	80
81	UTILIZATION REVIEW--PHYSICIAN COMPENSATION	81
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	82

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2008.05  
08/14/2008 08:54

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	156	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	896.07	84
85 OBSERVATION BED COST	139787	85

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	NF
INPATIENT DAYS	1	1	1	1	1	1
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	3785					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3532					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3532					4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	220					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	33					7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	240					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						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						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						13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)						14
15 TOTAL NURSERY DAYS						15
16 TITLE V OR XIX NURSERY DAYS						16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	NF	
SWING-BED ADJUSTMENT							
	1	1	1	1	1	1	
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	98.28						19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	98.28						20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3365298						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	3243						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	200378						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3164920						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2154000						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2154000						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.469322						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	609.85						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3164920						37

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	896.07					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	215057					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	215057					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	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
	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	207830					48
49 TOTAL PROGRAM INPATIENT COSTS	422887					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	12982					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	20156					51
52 TOTAL PROGRAM EXCLUDABLE COST	33138					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS						53

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II (CONT)

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION						
54	1	1	1	1	1	54
54						PROGRAM DISCHARGES
55						TARGET AMOUNT PER DISCHARGE
56						TARGET AMOUNT
57						DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58						BONUS PAYMENT
58.01						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET
58.02						LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET
58.03						IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT
58.04						RELIEF PAYMENT
59						ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01						ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)
59.02						PROGRAM DISCHARGES PRIOR TO JULY 1
59.03						PROGRAM DISCHARGES AFTER JULY 1
59.04						PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05						REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1
59.06						REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1
59.07						REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)
59.08						REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)
PROGRAM INPATIENT ROUTINE SWING BED COST						
60						MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
61						MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
62						TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64						TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65						TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

[ ] TITLE V-INPT [ ] TITLE XVIII-PART A [XX] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

NF

1

66 SNF/NF/ICF/MR ROUTINE SERVICE COST	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	67
68 PROGRAM ROUTINE SERVICE COST	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	71
72 PER DIEM CAPITAL RELATED COSTS	72
73 PROGRAM CAPITAL RELATED COSTS	73
74 INPATIENT ROUTINE SERVICE COST	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	77
78 INPATIENT ROUTINE SERVICE COST LIMITATION	78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION	81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	82

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2008.05  
08/14/2008 08:54

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
PARTS III & IV

TITLE V-INPT

TITLE XVIII-PART A

TITLE XIX-INPT

HOSPITAL (OTHER) (14-1345)	SUB I	SUB II	SUB III	SUB IV
1	1	1	1	1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS	156	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	896.07	84
85 OBSERVATION BED COST	139787	85

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V [XX] HOSPITAL (14-1345) [ ] SNF [ ] PPS  
 [XX] TITLE XVIII-PT A [ ] SUB I [ ] NF [ ] TEFRA  
 [ ] TITLE XIX [ ] SUB II [ ] S/B-SNF [XX] OTHER  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		1543314		25
26 INTENSIVE CARE UNIT				26
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.881100	224096	197451	37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.264067	610556	161228	41
44 LABORATORY	.270297	1019689	275619	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.508267	262473	133406	49
50 PHYSICAL THERAPY	.557522	51526	28727	50
53 ELECTROCARDIOLOGY	.191671	48822	9358	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.205541	895342	184029	55
56 DRUGS CHARGED TO PATIENTS	.484849	739311	358454	56
OUTPATIENT SERVICE COST CENTERS				
60.01 SALEM MEDICAL CLINIC				60.01
61 EMERGENCY	.654570	1308	856	61
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS	2.163350	1490	3223	62
63.50 PHOTOS RHC	1.878945			63.50
63.60 FQHC				63.60
101 TOTAL		3854613	1352351	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		3854613		103

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

<input type="checkbox"/> TITLE V	<input type="checkbox"/> HOSPITAL	<input type="checkbox"/> SNF	<input type="checkbox"/> PPS
<input checked="" type="checkbox"/> TITLE XVIII-PT A	<input type="checkbox"/> SUB I	<input type="checkbox"/> NF	<input type="checkbox"/> TEFRA
<input type="checkbox"/> TITLE XIX	<input type="checkbox"/> SUB II	<input checked="" type="checkbox"/> S/B-SNF (14-Z345)	<input checked="" type="checkbox"/> OTHER
	<input type="checkbox"/> SUB III	<input type="checkbox"/> S/B-NF	
	<input type="checkbox"/> SUB IV	<input type="checkbox"/> ICF/MR	

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS				25
26 INTENSIVE CARE UNIT				26
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.881100			37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.264067	4933	1303	41
44 LABORATORY	.270297	35665	9640	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.508267	24848	12629	49
50 PHYSICAL THERAPY	.557522	43489	24246	50
53 ELECTROCARDIOLOGY	.191671	475	91	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.205541	33927	6973	55
56 DRUGS CHARGED TO PATIENTS	.484849	48017	23281	56
OUTPATIENT SERVICE COST CENTERS				
60.01 SALEM MEDICAL CLINIC				60.01
61 EMERGENCY	.654570			61
62 OBSERVATION BEDS (NON-DISTINCT	2.163350			62
OTHER REIMBURSABLE COST CENTERS				
63.50 PHOTOS RHC	1.878945			63.50
63.60 FQHC				63.60
101 TOTAL		191354	78163	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		191354		103



CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
DRG AMOUNT						
1 OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1						1
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1						1.01
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS						1.02
1.03 PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1						1.03
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1						1.04
1.05 PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08 SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2 OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01 OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT						2.01
3 BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD						3
3.01 NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.06
						[ FOR CR PERIODS ENDING ]
						[ ON OR AFTER 7/1/2005 ]
						[E-3,PT.VI,LN.15][PLUS LN.3.06]
3.07 SUM OF LINES 3.04-3.06		0.00		0.00		3.07
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS						3.08
3.09 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13 FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14 CURRENT YEAR ALLOWABLE FTE						3.14
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.15
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.16
						RES. IN
						INIT YRS
3.17 SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO				0.00		3.17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A  
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
3.18						3.18
3.19						3.19
3.20						3.20
3.21						3.21
3.22						3.22
3.23						3.23
3.24						3.24
4						4
4.01						4.01
4.02						4.02
4.03						4.03
4.04						4.04
5						5
5.01						5.01
5.02						5.02
5.03						5.03
5.04						5.04
5.05						5.05
5.06						5.06
6						6
7						7
7.01						7.01
8						8
9						9
10						10
11						11
11.01						11.01
11.02						11.02
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
21.01						21.01
21.02						21.02
22						22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A  
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23						23
						RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION
24						24
						OTHER ADJUSTMENTS
25						25
						AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS
26						26
						AMOUNT DUE PROVIDER
27						27
						SEQUESTRATION ADJUSTMENT
28						28
						INTERIM PAYMENTS
28.01						28.01
						TENTATIVE SETTLEMENT (FOR FI USE ONLY)
29						29
						BALANCE DUE PROVIDER (PROGRAM)
30						30
						PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2
						TO BE COMPLETED BY INTERMEDIARY
50						50
						OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01
51						51
						CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01
52						52
						OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIO
53						53
						CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
54						54
						THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
55						55
						TIME VALUE OF MONEY (SEE INSTRUCTIONS)
56						56
						CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1345) 1	HOSPITAL (14-1345) 1.01	HOSPITAL (14-1345) 1.02	
1 MEDICAL AND OTHER SERVICES	3819946			1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST	3819946			5
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				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				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES	3858145			17
17.01 TOTAL PPS PAYMENTS				17.01

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (14-1345) 1	HOSPITAL (14-1345) 1.01	HOSPITAL (14-1345) 1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	57639		18
18.01 COINSURANCE	1540618		18.01
19 SUBTOTAL	2259888		19
20 SUM OF AMOUNTS FROM WKST E, PARTS C,D & E			20
21 DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS			21
22 ESRD DIRECT MEDICAL EDUCATION COSTS			22
23 SUBTOTAL	2259888		23
24 PRIMARY PAYER PAYMENTS	399		24
25 SUBTOTAL	2259489		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	249322		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	249322		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	242861		27.02
28 SUBTOTAL	2508811		28
29 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION			29
30 OTHER ADJUSTMENTS			30
30.99 OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)			30.99
31 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			31
32 SUBTOTAL	2508811		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	2335997		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	172814		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[ ] TITLE V            [XX] TITLE XVIII            [ ] TITLE XIX

HOSPITAL  
(14-1345)  
OCTOBER 1, 1997  
PRIOR TO    ON OR AFTER  
1            1.01

1 STANDARD OVERHEAD AMOUNTS (ASC FEES)	1
2 DEDUCTIBLES	2
3 SUBTOTAL	3
4 80 PERCENT OF LINE 3	4
5 ASC PORTION OF BLEND	5
6 OUTPATIENT ASC COST	6
COMPUTATION OF LESSER OF COST OR CHARGES	
7 TOTAL CHARGES	7
CUSTOMARY CHARGES	
8 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9 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)	9
10 RATIO OF LINE 8 TO LINE 9	10
11 TOTAL CUSTOMARY CHARGES	11
12 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14 LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT	
15 DEDUCTIBLES AND COINSURANCE	15
16 TOTAL	16
17 HOSPITAL SPECIFIC PORTION OF BLEND	17
18 ASC BLENDED AMOUNT	18
19 LESSER OF LINES 16 OR 18	19
20 PART B DEDUCTIBLES AND COINSURANCE	20
21 ASC PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[ ] TITLE V            [XX] TITLE XVIII            [ ] TITLE XIX

HOSPITAL  
(14-1345)  
OCTOBER 1, 1997  
PRIOR TO    ON OR AFTER  
1            1.01

1	PREVAILING CHARGES	1
2	62 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OUTPATIENT RADIOLOGY	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	RADIOLOGY PAYMENT AMOUNT	21

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[ ] TITLE V            [XX] TITLE XVIII            [ ] TITLE XIX

HOSPITAL  
(14-1345)  
OCTOBER 1, 1997  
PRIOR TO    ON OR AFTER  
1            1.01

1	PREVAILING CHARGES	1
2	42 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	DIAGNOSTIC PAYMENT AMOUNT	21

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 HOSPITAL (14-1345)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B		
	PART A		PART B		
	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3104843		2209997	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.		NONE		NONE	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.	.01 PROGRAM .02 TO .03 PROVIDER .04 .05 .50 PROVIDER .51 TO .52 PROGRAM .53 .54	09/21/2007 31000	09/21/2007	126000	3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54
SUBTOTAL	.99	31000		126000	3.99
4 TOTAL INTERIM PAYMENTS		3135843		2335997	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .50 TO .51 PROGRAM .52		NONE	NONE	5.01 5.02 5.03 5.50 5.51 5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01 PROVIDER TO .02 PROGRAM	108689		172814	6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		3244532		2508811	7

NAME OF INTERMEDIARY: \_\_\_\_\_  
 SIGNATURE OF AUTHORIZED PERSON: \_\_\_\_\_

INTERMEDIARY NUMBER: \_\_\_\_\_  
 DATE (MO/DAY/YR): \_\_\_\_\_

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 SWING BED SKILLED NURSING FACILITY (14-Z345)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B	
	PART A			
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		217532		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.		NONE		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.	PROGRAM .01			3.01
	TO .02			3.02
	PROVIDER .03	NONE		3.03
	TO .04		NONE	3.04
	PROVIDER .05			3.05
	TO .50			3.50
	PROVIDER .51			3.51
	TO .52	NONE		3.52
	PROVIDER .53		NONE	3.53
	PROGRAM .54			3.54
SUBTOTAL	.99			3.99
4 TOTAL INTERIM PAYMENTS		217532		4
TO BE COMPLETED BY INTERMEDIARY				
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01			5.01
	TO .02	NONE		5.02
	PROVIDER .03			5.03
	PROVIDER .50			5.50
	TO .51	NONE		5.51
	PROGRAM .52			5.52
SUBTOTAL	.99			5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	55000		6.01
	PROVIDER TO .02			6.02
PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		272532		7
NAME OF INTERMEDIARY: _____	INTERMEDIARY NUMBER: _____			
SIGNATURE OF AUTHORIZED PERSON: _____	DATE (MO/DAY/YR): _____			

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 SWING BEDS

SUPPLEMENTAL  
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

	TITLE V	--- TITLE XVIII ---		--- TITLE XIX ---		
	S/B NF	S/B SNF	S/B SNF	S/B SNF	S/B NF	
	1	1	2	1	1	
		(14-Z345)		(14-Z345)		
		PART A	PART B			
1	INPATIENT ROUTINE SERVICES - SWING BED - SNF					1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES					3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS		220			5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL		278052			8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL		278052			10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL		278052			12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		5520			13
14	80% OF PART B COSTS					14
15	SUBTOTAL		272532			15
16	OTHER ADJUSTMENTS					16
17	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PHYSICIAN PROFESSIONAL SERVICES)					17
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES					17.01
18	TOTAL		272532			18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS		217532			20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM		55000			21
22	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					22

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1345)	SUB I	SUB II	SUB III	SUB IV	SNF I
1 INPATIENT SERVICES	3565644					1
1.01 NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)						1.01
2 ORGAN ACQUISITION						2
3 COST OF TEACHING PHYSICIANS						3
4 SUBTOTAL	3565644					4
5 PRIMARY PAYER PAYMENTS						5
6 TOTAL COST	3601300					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 TEACHING PHYSICIANS						10
11 TOTAL REASONABLE CHARGES						11
12 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENT LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS						12
13 AMOUNT 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)						13
14 RATIO OF LINE 12 TO LINE 13						14
15 TOTAL CUSTOMARY CHARGES						15
16 EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						16
17 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						17

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART II

PART II - MEDICARE, PART A SERVICES - COST REIMBURSEMENT

	HOSPITAL (14-1345)	SUB I	SUB II	SUB III	SUB IV	SNF I
COMPUTATION OF REIMBURSEMENT SETTLEMENT						
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS					18
19	COST OF COVERED SERVICES	3601300				19
20	DEDUCTIBLES	419803				20
21	EXCESS REASONABLE COST					21
22	SUBTOTAL	3181497				22
23	COINSURANCE	4568				23
24	SUBTOTAL	3176929				24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	67603				25
25.01	REDUCED REIMBURSABLE BAD DEBTS	67603				25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	65587				25.02
26	SUBTOTAL	3244532				26
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION					27
28	OTHER ADJUSTMENTS					28
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS					29
30	SUBTOTAL	3244532				30
31	SEQUESTRATION ADJUSTMENT					31
32	INTERIM PAYMENTS	3135843				32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					32.01
33	BALANCE DUE PROVIDER/PROGRAM	108689				33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2					34

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3  
 PART III

		[ ] TITLE V	[ ] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (14-1345) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I	
	COMPUTATION OF NET COST OF COVERED SERVICES	1	1	1	1	1	1	
1	INPATIENT HOSPITAL/SNF/NF SERVICES	422887						1
2	MEDICAL AND OTHER SERVICES							2
3	INTERNS AND RESIDENTS							3
4	ORGAN ACQUISITION CERTIFIED TRANSPLANT CENTERS O							4
5	COST OF TEACHING PHYSICIANS							5
6	SUBTOTAL	422887						6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL	422887						9
	COMPUTATION OF LESSER OF COST OR CHARGES							
10	ROUTINE SERVICE CHARGES							10
11	ANCILLARY SERVICE CHARGES	526987						11
12	INTERNS AND RESIDENTS SERVICE CHARGES							12
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE							13
14	TEACHING PHYSICIANS							14
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION							15
16	TOTAL REASONABLE CHARGES							16
	CUSTOMARY CHARGES							
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE							17
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)							18
19	RATIO OF LINE 17 TO LINE 18							19
20	TOTAL CUSTOMARY CHARGES							20
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST							21
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES							22
23	COST OF COVERED SERVICES	422887						23
	PROSPECTIVE PAYMENT AMOUNT							
24	OTHER THAN OUTLIER PAYMENTS							24
25	OUTLIER PAYMENTS							25
26	PROGRAM CAPITAL PAYMENTS							26
27	CAPITAL EXCEPTION PAYMENTS							27
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS							28
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS							29
30	SUBTOTAL	422887						30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							31
32	LESSER OF LINES 30 OR 31	422887						32
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)							33

CALCULATION OF REIMBURSEMENT SETTLEMENT  
 PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

WORKSHEET E-3  
 PART III

	[ ] TITLE V	[ ] TITLE XVIII	[XX] TITLE XIX				
		HOSPITAL (14-1345) (OTHER)	SUB I	SUB II	SUB III	SUB IV	NF I
		1	1	1	1	1	1
COMPUTATION OF REIMBURSEMENT SETTLEMENT							
34	EXCESS OF REASONABLE COST						34
35	SUBTOTAL	422887					35
36	COINSURANCE						36
37	SUM OF AMOUNTS FROM WKST E, PARTS C,D AND E,						37
38	REIMBURSABLE BAD DEBTS						38
38.01	REDUCED REIMBURSABLE BAD DEBTS						38.01
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)						38.02
39	UTILIZATION REVIEW						39
40	SUBTOTAL	422887					40
41	INPATIENT ROUTINE SERVICE COST						41
42	MEDICARE INPATIENT ROUTINE CHARGES						42
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE						43
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)						44
45	RATIO OF LINE 43 TO LINE 44						45
46	TOTAL CUSTOMARY CHARGES						46
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST						47
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES						48
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM UTILIZATION						49
50	OTHER ADJUSTMENTS						50
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING DEPRECIABLE ASSETS						51
52	SUBTOTAL	422887					52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT						53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	422887					55
56	SEQUESTRATION ADJUSTMENT						56
57	INTERIM PAYMENTS						57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						57.01
58	BALANCE DUE PROVIDER/PROGRAM	422887					58
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT SECTION 115.2						59

BALANCE SHEET

WORKSHEET G

ASSETS		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT ASSETS					
1	CASH ON HAND AND IN BANKS	1008009			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	4952594			4
5	OTHER RECEIVABLES	45679			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1732000			6
7	INVENTORY	219606			7
8	PREPAID EXPENSES	516338			8
9	OTHER CURRENT ASSETS	521553			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	5531779			11
FIXED ASSETS					
12	LAND	61162			12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	828346			13
13.01	ACCUMULATED DEPRECIATION	-459682			13.01
14	BUILDINGS	10757604			14
14.01	ACCUMULATED DEPRECIATION	-4790791			14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT	1512989			16
16.01	ACCUMULATED DEPRECIATION	-636930			16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	7118489			18
18.01	ACCUMULATED DEPRECIATION	-4245596			18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	10145591			21
OTHER ASSETS					
22	INVESTMENTS	6024012			22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	455825			25
26	TOTAL OTHER ASSETS	6479837			26
27	TOTAL ASSETS	22157207			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	766660			28
29	SALARIES, WAGES & FEES PAYABLE	959392			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)	195000			31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES	133442			35
36	TOTAL CURRENT LIABILITIES	2054494			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE	2765000			37
38	NOTES PAYABLE				38
39	UNSECURED LOANS				39
40	LOANS FROM OWNERS .01 PRIOR TO 7/1/66 .02 ON OR AFTER 7/1/66				40
41	OTHER LONG TERM LIABILITIES				41
42	TOTAL LONG TERM LIABILITIES	2765000			42
43	TOTAL LIABILITIES	4819494			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	17337713			44
45	SPECIFIC PURPOSE FUND BALANCE				45
46	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				46
47	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				47
48	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				48
49	PLANT FUND BALANCE - INVESTED IN PLANT				49
50	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				50
51	TOTAL FUND BALANCES	17337713			51
52	TOTAL LIABILITIES AND FUND BALANCES	22157207			52

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	15673863			1
2 NET INCOME (LOSS)	1663850			2
3 TOTAL	17337713			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	17337713			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	17337713			19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	1952566		1952566	2
4 SUBPROVIDER I				4
5 SWING BED - SNF	56984		56984	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	2009550		2009550	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	201434		201434	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE	201434		201434	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	2210984		2210984	18
19 ANCILLARY SERVICES	6181313		6181313	19
20 OUTPATIENT SERVICES		26048948	26048948	20
18.50 PHOTOS RHC		299639	299639	18.50
18.60 FQHC				18.60
19 HOME HEALTH AGENCY		329818	329818	19
20 AMBULANCE				20
21 CORF				21
22 ASC				22
23 HOSPICE				23
24				24
25 TOTAL PATIENT REVENUES	8392297	26678405	35070702	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		18612764	26
27 ADD (SPECIFY)			27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS			33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		18612764	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	35070702	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	15771464	2
3	NET PATIENT REVENUES	19299238	3
4	LESS - TOTAL OPERATING EXPENSES	18612764	4
5	NET INCOME FROM SERVICE TO PATIENTS	686474	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	195558	6
7	INCOME FROM INVESTMENTS	263539	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		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	122766	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	357	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE	35700	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	PROPERTY TAX REVENUE	337284	24
24.01	OTHER OPERATING INCOME	31144	24.01
24.02	LOSS ON DISPOSITION OF EQUIPMENT	-39488	24.02
24.03	NONCAPITAL GRANTS AND CONTRIBUTIONS	30516	24.03
25	TOTAL OTHER INCOME	977376	25
26	TOTAL	1663850	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	1663850	31

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7429

WORKSHEET H

	SALARIES	EMPLOYEE	TRANS-	CONTRACTED/	OTHER	TOTAL HHA
	1	BENEFITS	PORTATION	PURCH SVCS	COSTS	COST
		2	3	4	5	6
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED-BLDG & FIXTURES						1
2 CAPITAL RELATED-MOVABLE EQUIPMENT						2
3 PLANT OPERATION & MAINTENANCE						3
4 TRANSPORTATION						4
5 ADMINISTRATIVE AND GENERAL	78530	5616	312		20542	105000
6 HHA REIMBURSABLE SERVICES						
6 SKILLED NURSING CARE	126229	9026	6016			141271
7 PHYSICAL THERAPY				24378		24378
8 OCCUPATIONAL THERAPY				3136		3136
9 SPEECH PATHOLOGY				167		167
10 MEDICAL SOCIAL SERVICES				126		126
11 HOME HEALTH AIDE	1740	124	524			2388
12 SUPPLIES					1904	1904
13 DRUGS						13
13.20 COST OF ADMINISTERING VACCINES						13.20
14 DME						14
HHA NONREIMBURSABLE SERVICES						
15 HOME DIALYSIS AIDE SERVICES						15
16 RESPIRATORY THERAPY						16
17 PRIVATE DUTY NURSING						17
18 CLINIC						18
19 HEALTH PROMOTION ACTIVITIES						19
20 DAY CARE PROGRAM						20
21 HOME DELIVERED MEALS PROGRAM						21
22 HOMEMAKER SERVICE						22
23 ALL OTHERS						23
23.50 TELEMEDICINE						23.50
24 TOTAL	206499	14766	6852	27807	22446	278370

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA NO.: 14-7429

WORKSHEET H  
 (CONTINUED)

	RECLASSIFI- CATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	NET EXPENSES FOR ALLOCATION 10	
GENERAL SERVICE COST CENTER					
1 CAPITAL RELATED-BLDG & FIXTURES					1
2 CAPITAL RELATED-MOVABLE EQUIPMENT					2
3 PLANT OPERATION & MAINTENANCE					3
4 TRANSPORTATION					4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES		105000		105000	5
6 SKILLED NURSING CARE		141271		141271	6
7 PHYSICAL THERAPY		24378		24378	7
8 OCCUPATIONAL THERAPY		3136		3136	8
9 SPEECH PATHOLOGY		167		167	9
10 MEDICAL SOCIAL SERVICES		126		126	10
11 HOME HEALTH AIDE		2388		2388	11
12 SUPPLIES		1904		1904	12
13 DRUGS					13
13.20 COST OF ADMINISTERING VACCINES					13.20
14 DME HHA NONREIMBURSABLE SERVICES					14
15 HOME DIALYSIS AIDE SERVICES					15
16 RESPIRATORY THERAPY					16
17 PRIVATE DUTY NURSING					17
18 CLINIC					18
19 HEALTH PROMOTION ACTIVITIES					19
20 DAY CARE PROGRAM					20
21 HOME DELIVERED MEALS PROGRAM					21
22 HOMEMAKER SERVICE					22
23 ALL OTHERS					23
23.50 TELEMEDICINE					23.50
24 TOTAL		278370		278370	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7429

WORKSHEET H-4  
 PART I

	NET EXPENSES FOR COST ALLOCATION	CAP REL BLDGS & FIXTURES	CAP REL MOVABLE EQUIPMENT	PLANT OPERATN & MAINT	TRANSPORT- ATION	SUBTOTAL 4A	ADMIN & GENERAL 5	TOTAL 6
	0	1	2	3	4			
GENERAL SERVICE COST CENTER								
1 CAPITAL RELATED-BLDG & FIXT								1
2 CAPITAL RELATED-MOVABLE EQUIP								2
3 PLANT OPERATION & MAINTENANCE								3
4 TRANSPORTATION								4
5 ADMINISTRATIVE AND GENERAL	105000					105000	105000	5
HHA REIMBURSABLE SERVICES								
6 SKILLED NURSING CARE	141271					141271	85561	226832 6
7 PHYSICAL THERAPY	24378					24378	14764	39142 7
8 OCCUPATIONAL THERAPY	3136					3136	1899	5035 8
9 SPEECH PATHOLOGY	167					167	101	268 9
10 MEDICAL SOCIAL SERVICES	126					126	76	202 10
11 HOME HEALTH AIDE	2388					2388	1446	3834 11
12 SUPPLIES	1904					1904	1153	3057 12
13 DRUGS								13
13.20 COST OF ADMINISTERING VACCINES								13.20
14 DME								14
HHA NONREIMBURSABLE SERVICES								
15 HOME DIALYSIS AIDE SERVICES								15
16 RESPIRATORY THERAPY								16
17 PRIVATE DUTY NURSING								17
18 CLINIC								18
19 HEALTH PROMOTION ACTIVITIES								19
20 DAY CARE PROGRAM								20
21 HOME DELIVERED MEALS PROGRAM								21
22 HOMEMAKER SERVICE								22
23 ALL OTHERS								23
23.50 TELEMEDICINE								23.50
24 TOTAL	278370					278370		278370 24

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (05/2007)

VERSION: 2008.05  
 08/14/2008 08:54

COST ALLOCATION - HHA STATISTICAL BASIS

HHA NO.: 14-7429

WORKSHEET H-4  
 PART II

	CAP REL BLDGS & FIXTURES (SQUARE FEET) 1	CAP REL MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATN & MAINT (SQUARE FEET) 3	TRANSPORT- ATION (MILEAGE) 4	RECONCIL- IATION 5A	ADMIN & GENERAL (ACCUM COST) 5	
GENERAL SERVICE COST CENTER							
1 CAPITAL RELATED-BLDG & FIXT							1
2 CAPITAL RELATED-MOVABLE EQUIP							2
3 PLANT OPERATION & MAINTENANCE							3
4 TRANSPORTATION							4
5 ADMINISTRATIVE AND GENERAL HHA REIMBURSABLE SERVICES					-105000	173370	5
6 SKILLED NURSING CARE						141271	6
7 PHYSICAL THERAPY						24378	7
8 OCCUPATIONAL THERAPY						3136	8
9 SPEECH PATHOLOGY						167	9
10 MEDICAL SOCIAL SERVICES						126	10
11 HOME HEALTH AIDE						2388	11
12 SUPPLIES						1904	12
13 DRUGS							13
13.20 COST OF ADMINISTERING VACCINES							13.20
14 DME							14
HHA NONREIMBURSABLE SERVICES							
15 HOME DIALYSIS AIDE SERVICES							15
16 RESPIRATORY THERAPY							16
17 PRIVATE DUTY NURSING							17
18 CLINIC							18
19 HEALTH PROMOTION ACTIVITIES							19
20 DAY CARE PROGRAM							20
21 HOME DELIVERED MEALS PROGRAM							21
22 HOMEMAKER SERVICE							22
23 ALL OTHERS							23
23.50 TELEMEDICINE							23.50
24 TOTAL					-105000	173370	24
25 COST TO BE ALLOC (PER W/S H)						105000	25
26 UNIT COST MULTIPLIER						.605641	26







ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7429

WORKSHEET H-5  
 PART I

HHA COST CENTER	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL	ALLOCATED HHA A & G	
	21	22	23	24	25	26	27	28	
1 ADMINISTRATIVE AND GENERAL					82124		82124		1
2 SKILLED NURSING CARE					281897		281897	68470	2
3 PHYSICAL THERAPY					42311		42311	10277	3
4 OCCUPATIONAL THERAPY					5443		5443	1322	4
5 SPEECH PATHOLOGY					290		290	70	5
6 MEDICAL SOCIAL SERVICES					218		218	53	6
7 HOME HEALTH AIDE					4647		4647	1129	7
8 SUPPLIES					3304		3304	803	8
9 DRUGS									9
9.20 COST OF ADMINISTERING VACC									9.20
10 DME									10
11 HOME DIALYSIS AIDE SERVICE									11
12 RESPIRATORY THERAPY									12
13 PRIVATE DUTY NURSING									13
14 CLINIC									14
15 HEALTH PROMOTION ACTIVITIE									15
16 DAY CARE PROGRAM									16
17 HOME DELIVERED MEALS PROGR									17
18 HOMEMAKER SERVICE									18
19 ALL OTHERS									19
19.50 TELEMEDICINE									19.50
20 TOTALS					420234		420234	82124	20
21 UNIT COST MULTIPLIER								.242891	21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA NO.: 14-7429

WORKSHEET H-5  
 PART I

HHA COST CENTER	TOTAL HHA COSTS 29	
1 ADMINISTRATIVE AND GENERAL		1
2 SKILLED NURSING CARE	350367	2
3 PHYSICAL THERAPY	52588	3
4 OCCUPATIONAL THERAPY	6765	4
5 SPEECH PATHOLOGY	360	5
6 MEDICAL SOCIAL SERVICES	271	6
7 HOME HEALTH AIDE	5776	7
8 SUPPLIES	4107	8
9 DRUGS		9
9.20 COST OF ADMINISTERING VACC		9.20
10 DME		10
11 HOME DIALYSIS AIDE SERVICE		11
12 RESPIRATORY THERAPY		12
13 PRIVATE DUTY NURSING		13
14 CLINIC		14
15 HEALTH PROMOTION ACTIVITIE		15
16 DAY CARE PROGRAM		16
17 HOME DELIVERED MEALS PROGR		17
18 HOMEMAKER SERVICE		18
19 ALL OTHERS		19
19.50 TELEMEDICINE		19.50
20 TOTALS	420234	20
21 UNIT COST MULTIPLIER		21

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7429

WORKSHEET H-5  
 PART II

HHA COST CENTER	OLD CAP BLDGS & FIXTURES SQUARE FEET	OLD CAP MOVABLE EQUIPMENT DOLLAR VALUE	NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINISTRA TIVE & ACC OUNTING ACCUM COST	BUSINESS S ERVICES GROSS CHAR GES
	1	2	3	4	5	6A.01	6.01	6.02
1 ADMINISTRATIVE AND GENERAL			1320	3625	78530		34691	1
2 SKILLED NURSING CARE					126229		260534	2
3 PHYSICAL THERAPY							39142	3
4 OCCUPATIONAL THERAPY							5035	4
5 SPEECH PATHOLOGY							268	5
6 MEDICAL SOCIAL SERVICES							202	6
7 HOME HEALTH AIDE					1740		4299	7
8 SUPPLIES							3057	8
9 DRUGS								9
9.20 COST OF ADMINISTERING VACC								9.20
10 DME								10
11 HOME DIALYSIS AIDE SERVICE								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIE								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGR								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTALS			1320	3625	206499		347228	20
21 TOTAL COST TO BE ALLOCATED			10100	3624	55134		28111	21
22 UNIT COST MULTIPLIER			7.651515		.266994		.080958	22
22 UNIT COST MULTIPLIER				.999724				22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7429

WORKSHEET H-5  
 PART II

HHA COST CENTER	MAIN- TENANCE & REPAIRS SQUARE FEET 7	OPERATION OF PLANT SQUARE FEET 8	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY 9	HOUSE- KEEPING HOURS OF SERVICE 10	DIETARY MEALS SERVED 11	CAFETERIA MEALS SERVED 12	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED 13	NURSING ADMINIS- TRATION DIRECT NRSING HRS 14
1 ADMINISTRATIVE AND GENERAL		1320		20		470		1
2 SKILLED NURSING CARE								2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
9.20 COST OF ADMINISTERING VACC								9.20
10 DME								10
11 HOME DIALYSIS AIDE SERVICE								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIE								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGR								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTALS		1320		20		470		20
21 TOTAL COST TO BE ALLOCATED		23590		4778		15466		21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER		17.871212		238.900000		32.906383		22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7429

WORKSHEET H-5  
 PART II

HHA COST CENTER	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15	PURCHASING COSTED REQUIS. 15.01	CENTRAL SERVICES & SUPPLY COSTED REQUIS. 15.02	PHARMACY COSTED REQUIS. 16	MEDICAL RECORDS & LIBRARY TIME SPENT 17	SOCIAL SERVICE TIME SPENT 18	NONPHYSIC. ANESTHET. ASSIGNED TIME 20	NURSING SCHOOL ASSIGNED TIME 21
1 ADMINISTRATIVE AND GENERAL		4278						1
2 SKILLED NURSING CARE			1904					2
3 PHYSICAL THERAPY								3
4 OCCUPATIONAL THERAPY								4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE								7
8 SUPPLIES								8
9 DRUGS								9
9.20 COST OF ADMINISTERING VACC								9.20
10 DME								10
11 HOME DIALYSIS AIDE SERVICE								11
12 RESPIRATORY THERAPY								12
13 PRIVATE DUTY NURSING								13
14 CLINIC								14
15 HEALTH PROMOTION ACTIVITIE								15
16 DAY CARE PROGRAM								16
17 HOME DELIVERED MEALS PROGR								17
18 HOMEMAKER SERVICE								18
19 ALL OTHERS								19
19.50 TELEMEDICINE								19.50
20 TOTALS		4278	1904					20
21 TOTAL COST TO BE ALLOCATED		790	271					21
22 UNIT COST MULTIPLIER			.142332					22
22 UNIT COST MULTIPLIER		.184666						22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS  
 STATISTICAL BASIS

HHA NO.: 14-7429

WORKSHEET H-5  
 PART II

HHA COST CENTER	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME	
	22	23	24	
1 ADMINISTRATIVE AND GENERAL				1
2 SKILLED NURSING CARE				2
3 PHYSICAL THERAPY				3
4 OCCUPATIONAL THERAPY				4
5 SPEECH PATHOLOGY				5
6 MEDICAL SOCIAL SERVICES				6
7 HOME HEALTH AIDE				7
8 SUPPLIES				8
9 DRUGS				9
9.20 COST OF ADMINISTERING VACC				9.20
10 DME				10
11 HOME DIALYSIS AIDE SERVICE				11
12 RESPIRATORY THERAPY				12
13 PRIVATE DUTY NURSING				13
14 CLINIC				14
15 HEALTH PROMOTION ACTIVITIE				15
16 DAY CARE PROGRAM				16
17 HOME DELIVERED MEALS PROGR				17
18 HOMEMAKER SERVICE				18
19 ALL OTHERS				19
19.50 TELEMEDICINE				19.50
20 TOTALS				20
21 TOTAL COST TO BE ALLOCATED				21
22 UNIT COST MULTIPLIER				22
22 UNIT COST MULTIPLIER				22

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA NO.: 14-7429

WORKSHEET H-6  
 PARTS I & II

CHECK APPLICABLE BOX: [ ] TITLE V [  ] TITLE XVIII [ ] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS: COMPUTATION OF THE LESSER OF AGGREGATE PROGRAM COST OR THE AGGREGATE OF THE PROGRAM LIMITATION

COST PER VISIT COMPUTATION		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL	AVERAGE	
PATIENT SERVICES		WKST H-5, PART I, COL 29, LINE	COSTS	ANCILLARY COSTS	COSTS	VISITS	COST PER VISIT	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	350367		350367	1059	330.85	1
2	PHYSICAL THERAPY	3	52588		52588	583	90.20	2
3	OCCUPATIONAL THERAPY	4	6765		6765	75	90.20	3
4	SPEECH PATHOLOGY	5	360		360	4	90.00	4
5	MEDICAL SOCIAL SERV	6	271		271	3	90.33	5
6	HOME HEALTH AIDE SERV	7	5776		5776	211	27.37	6
7	TOTAL		416127		416127	1935		7
LIMITATION COST COMPUTATION			MSA				PROGRAM	
PATIENT SERVICES			NO.				COST	
							LIMITS	
			1	2	3	4	5	
8	SKILLED NURSING CARE		9914					8
9	PHYSICAL THERAPY		9914					9
10	OCCUPATIONAL THERAPY		9914					10
11	SPEECH PATHOLOGY		9914					11
12	MEDICAL SOCIAL SERV		9914					12
13	HOME HEALTH AIDE SERV		9914					13
14	TOTAL							14
SUPPLIES AND DRUGS COST COMPUTATIONS		FROM	FACILITY	SHARED	TOTAL HHA	TOTAL		
OTHER PATIENT SERVICES		WKST H-5, PART I, COL 29, LINE	COSTS	ANCILLARY COSTS	COSTS	CHARGES	RATIO	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	4107		4107			15
16	COST OF DRUGS	9						16
16.20	COST OF ADMINISTERING VACCINES	9.20						16.20
PER BENEFICIARY COST LIMITATION:						MSA		
						NO.	AMOUNT	
						1	2	
17	PROGRAM UNDUPLICATED CENSUS FROM WORKSHEET S-4					9914		17
18	PER BENEFICIARY COST LIMITATION					9914		18
19	PER BENEFICIARY COST LIMITATION							19





CALCULATION OF HHA REMBURSEMENT SETTLEMENT

HHA NO.: 14-7429

WORKSHEET H-7  
 PARTS I & II

CHECK APPLICABLE BOX: [ ] TITLE V [ XX ] TITLE XVIII [ ] TITLE XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

DESCRIPTION	PART A 1	----- PART B -----		
		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
1 REASONABLE COST OF PROGRAM SERVICES				1
2 REASONABLE COST OF SERVICES				1
2 TOTAL CHARGES				2
CUSTOMARY CHARGES				
3 AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				3
4 AMOUNT 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(B)				4
5 RATIO OF LINE 3 TO LINE 4 (NOT TO EXCEED 1.000000)				5
6 TOTAL CUSTOMARY CHARGES				6
7 EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST				7
8 EXCESS OF TOTAL REASONABLE COST OVER TOTAL CUSTOMARY CHARGES				8
9 PRIMARY PAYOR PAYMENTS				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10 TOTAL REASONABLE COST			10
10.01 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	184938	56812	10.01
10.02 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.02
10.03 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	5954	4763	10.03
10.04 TOTAL PPS REIMBURSEMENT - PEP EPISODES	12706	1176	10.04
10.05 TOTAL PPS REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.05
10.06 TOTAL PPS REIMBURSEMENT - SCIC EPISODES			10.06
10.07 TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.07
10.08 TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			10.08
10.09 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC WITHIN A PEP EPISODES			10.09
10.10 TOTAL PPS OUTLIER REIMBURSEMENT - SCIC EPISODES			10.10
10.11 TOTAL OTHER PAYMENTS			10.11
10.12 DME PAYMENTS			10.12
10.13 OXYGEN PAYMENTS			10.13
10.14 PROSTHETIC AND ORTHOTIC PAYMENTS			10.14
11 PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCL COINSURANCE)			11
12 SUBTOTAL	203598	62751	12
13 EXCESS REASONABLE COST			13
14 SUBTOTAL	203598	62751	14
15 COINSURANCE BILLED TO PROGRAM PATIENTS			15
16 NET COST	203598	62751	16
17 REIMBURSABLE BAD DEBTS			17
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			17.01
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	203598	62751	18
19 AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS			19
20 RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR OR DECREASE IN PROGRAM UTILIZATION			20
21 OTHER ADJUSTMENTS (SPECIFY):			21
22 SUBTOTAL	203598	62751	22
23 SEQUESTRATION ADJUSTMENT			23
24 SUBTOTAL	203598	62751	24
25 TOTAL INTERIM PAYMENTS	203598	62751	25
25.01 TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26 BALANCE DUE PROVIDER/PROGRAM			26
27 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2			27

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHA'S  
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

HHA NO.: 14-7429

WORKSHEET H-8

DESCRIPTION	PART A		PART B		
	MO/DAY/YR 1	AMOUNT 2	MO/DAY/YR 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		203598		62751	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.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM					
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .01				3.01
REVISION OF THE INTERIM RATE FOR THE COST	TO .02				3.02
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .03	NONE		NONE	3.03
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .04				3.04
	TO .05				3.05
	PROVIDER .50				3.50
	PROGRAM .51				3.51
	TO .52	NONE		NONE	3.52
	PROVIDER .53				3.53
	PROGRAM .54				3.54
SUBTOTAL	.99				3.99
4 TOTAL INTERIM PAYMENTS		203598		62751	4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01				5.01
	TO .02	NONE		NONE	5.02
	PROVIDER .03				5.03
	PROVIDER .50				5.50
	TO .51	NONE		NONE	5.51
	PROGRAM .52				5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01				6.01
	PROVIDER TO .02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		203598		62751	7
NAME OF INTERMEDIARY: _____	INTERMEDIARY NUMBER: _____				
SIGNATURE OF AUTHORIZED PERSON: _____	DATE (MO/DAY/YR): _____				

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	4A	25	26	27
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6.01 ADMINISTRATIVE & ACCOUNTING					6.01
6.02 BUSINESS SERVICES					6.02
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING					10
11 DIETARY					11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION					14
15 CENTRAL SERVICES & SUPPLY					15
15.01 PURCHASING					15.01
15.02 CENTRAL SERVICES & SUPPLY					15.02
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY					17
18 SOCIAL SERVICE					18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES A					22
23 I&R SERVICES-OTHER PRGM COSTS A					23
24 PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS					
25 ADULTS & PEDIATRICS					25
26 INTENSIVE CARE UNIT					26
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
40 ANESTHESIOLOGY					40
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN CO					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO PAT					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60.01 SALEM MEDICAL CLINIC					60.01
61 EMERGENCY					61
62 OBSERVATION BEDS (NON-DISTINCT)					62
63.50 PHOTOS RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03
95 SUBTOTALS					95
NONREIMBURSABLE COST CENTERS					
96 GIFT, FLOWER, COFFEE SHOP & CAN					96
98 PHYSICIANS' PRIVATE OFFICES					98
98.01 SALEM MEDICAL CENTER					98.01
98.02 WHITAKER BLDG					98.02
101 CROSS FOOT ADJUSTMENTS					101
102 NEGATIVE COST CENTER					102
103 TOTAL					103
104 TOTAL STATISTICAL BASIS					104
105 UNIT COST MULTIPLIER					105
105 UNIT COST MULTIPLIER					105

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2008.05  
 08/14/2008 08:54

RHC I  
 COMPONENT NO: 14-3413

WORKSHEET M-1

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/  
 FEDERALLY QUALIFIED HEALTH CENTER COSTS

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN								1
2 PHYSICIAN ASSISTANT	138996	10407	149403		149403		149403	2
3 NURSE PRACTITIONER								3
4 VISITING NURSE								4
5 OTHER NURSE	62142	4653	66795		66795		66795	5
6 CLINICAL PSYCHOLOGIST								6
7 CLINICAL SOCIAL WORKER								7
8 LABORATORY TECHNICIAN								8
9 OTHER FACILITY HEALTH CARE STAFF COSTS								9
10 SUBTOTAL (SUM OF LINES 1-9) COSTS UNDER AGREEMENT	201138	15060	216198		216198		216198	10
11 PHYSICIAN SERVICES UNDER AGREEMENT		154962	154962	29250	184212		184212	11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13) OTHER HEALTH CARE COSTS		154962	154962	29250	184212		184212	14
15 MEDICAL SUPPLIES		3001	3001		3001		3001	15
16 TRANSPORTATION (HEALTH CARE STAFF)								16
17 DEPRECIATION-MEDICAL EQUIPMENT								17
18 PROFESSIONAL LIABILITY INSURANCE								18
19 OTHER HEALTH CARE COSTS								19
20 ALLOWABLE GME COSTS								20
21 SUBTOTAL (SUM OF LINES 15-20)		3001	3001		3001		3001	21
22 TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES	201138	173023	374161	29250	403411		403411	22
23 PHARMACY								23
24 DENTAL								24
25 OPTOMETRY								25
26 ALL OTHER NONREIMBURSABLE COSTS								26
27 NONALLOWABLE GME COSTS								27
28 TOTAL NONREIMBURSABLE COSTS FACILITY OVERHEAD								28
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS	45444	9516	54960		54960		54960	30
31 TOTAL FACILITY OVERHEAD	45444	9516	54960		54960		54960	31
32 TOTAL FACILITY COSTS	246582	182539	429121	29250	458371		458371	32

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05  
 08/14/2008 08:54

RHC I  
 COMPONENT NO: 14-3413

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1 PHYSICIANS			4200			1
2 PHYSICIAN ASSISTANTS	1.55	3767	2100	3255		2
3 NURSE PRACTITIONERS			2100			3
4 SUBTOTAL	1.55	3767		3255	3767	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	1.55	3767			3767	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS		794			794	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					403411	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					403411	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					54960	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					186620	15
16 TOTAL OVERHEAD					241580	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					241580	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					241580	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					644991	20

RHC I  
 COMPONENT NO: 14-3413

WORKSHEET M-3

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

CHECK [ XX ] RHC [ ] TITLE V  
 APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
 [ ] TITLE XIX

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES	644991	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	26242	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	618749	3
4	TOTAL VISITS	3767	4
5	PHYSICIANS VISITS UNDER AGREEMENT	794	5
6	TOTAL ADJUSTED VISITS	4561	6
7	ADJUSTED COST PER VISIT	135.66	7

CALCULATION OF LIMIT(1)  
 PRIOR TO ON OR AFTER  
 JANUARY 1 JANUARY 1 (SEE INSTR.)  
 1 2 3

8	PER VISIT PAYMENT LIMIT			8
9	RATE FOR PROGRAM COVERED VISITS	135.66	135.66	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	262	88	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	35543	11938	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES			12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES			13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES			14
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST			15
16	TOTAL PROGRAM COST			47481 16
16.01	PRIMARY PAYOR PAYMENTS			16.01
17	LESS: BENEFICIARY DEDUCTIBLE			5149 17
18	NET PROGRAM COST EXCLUDING VACCINES			42332 18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE			33866 19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION			7052 20
21	TOTAL REIMBURSABLE PROGRAM COST			40918 21
22	REIMBURSABLE BAD DEBTS			22
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			22.01
23	OTHER ADJUSTMENTS			23
24	NET REIMBURSABLE AMOUNT			40918 24
25	INTERIM PAYMENTS			24646 25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)			25.01
26	BALANCE DUE COMPONENT/PROGRAM			16272 26
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2			27

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDAR YEAR PROVIDERS USE COLUMN 2 ONLY.

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2007 TO 03/31/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (9/2000)

VERSION: 2008.05  
08/14/2008 08:54

RHC I  
COMPONENT NO: 14-3413

WORKSHEET M-4

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

CHECK [ XX ] RHC [ ] TITLE V  
APPLICABLE BOX: [ ] FQHC [ XX ] TITLE XVIII  
[ ] TITLE XIX

	PNEUMOCOCCAL 1	INFLUENZA 2	
1 HEALTH CARE STAFF COSTS	216198	216198	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.025400	0.025400	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	5491	5491	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE		5431	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	5491	10922	5
6 TOTAL DIRECT COST OF THE FACILITY	403411	403411	6
7 TOTAL OVERHEAD	241580	241580	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.013611	0.027074	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	3288	6541	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	8779	17463	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS		421	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION		41.48	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES		170	13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		7052	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		26242	15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		7052	16

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER  
 FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

RHC I  
 COMPONENT NO: 14-3413

WORKSHEET M-5

CHECK [ XX ] RHC  
 APPLICABLE BOX: [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		24646	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.		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM	PROGRAM .01		3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	TO .02		3.02
REVISION OF THE INTERIM RATE FOR THE COST	PROVIDER .03	NONE	3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	TO .04		3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .05		3.05
	PROVIDER .50		3.50
	TO .51		3.51
	PROGRAM .52	NONE	3.52
	TO .53		3.53
	PROGRAM .54		3.54
SUBTOTAL	.99		3.99
4 TOTAL INTERIM PAYMENTS		24646	4
TO BE COMPLETED BY INTERMEDIARY			
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM .01		5.01
	TO .02	NONE	5.02
	PROVIDER .03		5.03
	PROVIDER .50		5.50
	TO .51	NONE	5.51
	PROGRAM .52		5.52
SUBTOTAL	.99		5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO .01	16272	6.01
	PROVIDER TO .02		6.02
	PROGRAM	40918	7
7 TOTAL MEDICARE PROGRAM LIABILITY			
NAME OF INTERMEDIARY: _____		INTERMEDIARY NUMBER: _____	
SIGNATURE OF AUTHORIZED PERSON: _____		DATE (MO/DAY/YR): _____	

\*\*\*\*\* REPORT 97 \*\*\*\*\* UTILIZATION STATISTICS \*\*\*\*\*

HOSPITAL

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD PARTY UTIL
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	
UTILIZATION PERCENTAGES BASED ON DAYS							
25 ADULTS & PEDIATRICS	69.93		6.80				76.73 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
37 OPERATING ROOM	11.77	36.73	2.08				50.58 37
41 RADIOLOGY-DIAGNOSTIC	6.20	36.72	0.99				43.91 41
44 LABORATORY	12.93	29.38	1.65				43.96 44
49 RESPIRATORY THERAPY	21.98	30.73	3.46				56.17 49
50 PHYSICAL THERAPY	3.47	34.19	0.21				37.87 50
53 ELECTROCARDIOLOGY	9.26	55.32	1.05				65.63 53
55 MEDICAL SUPPLIES CHARGED TO PAT	29.74	26.07	2.15				57.96 55
56 DRUGS CHARGED TO PATIENTS	34.06	24.63	5.47				64.16 56
61 EMERGENCY	0.05	36.42	1.07				37.54 61
62 OBSERVATION BEDS (NON-DISTINCT	2.31	63.60					65.91 62
101 TOTAL CHARGES	11.64	30.38	1.59				43.61 101



COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
69.20 OUTPATIENT PHYSICAL THERAPY							69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40 OUTPATIENT SPEECH PATHOLOGY							69.40
71 HOME HEALTH AGENCY	278370	1.76	141864	1.79	420234	2.66	71
SPECIAL PURPOSE COST CENTERS							
85.01 PANCREAS ACQUISITION							85.01
85.02 INTESTINAL ACQUISITION							85.02
85.03 ISLET CELL ACQUISITION							85.03
NONREIMBURSABLE COST CENTERS							
96 GIFT, FLOWER, COFFEE SHOP & CAN			13359	.17	13359	.08	96
98 PHYSICIANS' PRIVATE OFFICES	22981	.15	112166	1.41	135147	.85	98
98.01 SALEM MEDICAL CENTER			37		37		98.01
98.02 WHITAKER BLDG							98.02
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	15809395	100.00	0	.00	15809395	100.00	103

\*\*\*\* THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 x COLUMN 1.01 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	3537194
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPS. (WKST D, PART V, LINE 104, COLUMNS 2, 2.01, 3, 3.01, 4, 4.01, 5, 5.01, 5.03 & 5.04 LESS LINES 45, 50 - 52, 57, 64, 65 & SUBSCRIPTS, & 66)	9551046
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.370