

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 XX ELECTRONICALLY FILED COST REPORT DATE: 08/16/2010
 APPLICABLE BOX MANUALLY SUBMITTED COST REPORT TIME: 10:55

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 04/01/2009 AND ENDING 03/31/2010, 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.

ECR Encryption: 08/16/2010 10:55
 LdD2sBlPHnnAJegqYlR3xr5NDUs8G
 I2Yns0cNST05jad1Pb7FAwoCQhk98F
 uQIR0SmGh10pF2r1

(SIGNED)

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PI Encryption: 08/16/2010 10:55
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 hlqSE01PkFR1fkTuRSJXjApkEWIXGV
 c6tH8eyuP00g7QWp

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	2	3	4	1
2	SUBPROVIDER 1	192299	-189209	469310	2
3	SWING BED - SNF	45809			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		-43014		9
100	TOTAL	238108	-232223	469310	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1201 RICKER DRIVE
 1.01 CITY: SALEM

STATE: IL

P.O.BOX:
 ZIP CODE: 62881

COUNTY: MARION

1
 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)				
				V 4	XVIII 5	XIX 6		
2	HOSPITAL	SALEM TOWNSHIP HOSPITAL	14-1345	07/01/1966	N	O	O	2
3	SUBPROVIDER I							3
4	SWING BEDS - SNF	SALEM S/B SNF	14-2345	12/17/1986	N	O	N	4
5	SWING BEDS - NF							5
6	HOSPITAL-BASED SNF							6
7	HOSPITAL-BASED NF							7
8	HOSPITAL-BASED OLTC							8
9	HOSPITAL-BASED HHA	SALEM HOME HEALTH AGENCY	14-7429	08/01/1985	N	P	N	9
11	SEPARATELY CERTIFIED ASC							11
12	HOSPITAL-BASED HOSPICE							12
14	HOSP-BASED RHC	PHOTOS RURAL HEALTH CLINIC	14-3413	07/29/1996	N	O	N	14
15	OUTPATIENT REHABILITATION PROVID							15
16	RENAL DIALYSIS							16
17	COST REPORTING PERIOD (MM/DD/YYYY)		FROM: 04/01/2009	TO: 03/31/2010				17
18	TYPE OF CONTROL		1	2				18

TYPE OF HOSPITAL/SUBPROVIDER

19	HOSPITAL		1					19
20	SUBPROVIDER I							20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.							21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDMENT HOSPITALS)? ENTER IN COLUMN 2 'Y' OR 'N' FOR NO.							21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.							21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy)(SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.							21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.							21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.							21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105 OR MIPPA 147? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES AND 'N' FOR NO.							21.06
21.07	DOES THIS HOSPITAL QUALIFY AS AN SCH WITH UNDER 100 BEDS OR FEWER BEDS UNDER MIPPA 147? ENTER 'Y' FOR YES AND 'N' FOR NO (SEE INSTRUCTIONS).							21.07
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS? ENTER IN COLUMN 1, 1 IF IT IS BASED ON DATE OF ADMISSION, 2 IF IT IS BASED ON CENSUS DAYS, OR 3 IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE LAST COST REPORTING PERIOD? ENTER IN COLUMN 2, 'Y' FOR YES AND 'N' FOR NO.							21.08
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?							22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW							23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.							23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.							23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.							24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.							24.01

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?	NO		25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?	NO		25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.	NO		25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.	NO		25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2	NO		25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			25.06
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
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)				
28.03	STAFFING	0.00	NO	28.03
28.04	RECRUITMENT	0.00	NO	28.04
28.05	RETENTION OF EMPLOYEES	0.00	NO	28.05
28.06	TRAINING	0.00	NO	28.06
28.07	OTHER (SPECIFY)		NO	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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

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

PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL

36 DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? NO 36
 36.01 DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320? NO 36.01
 37 DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? NO 37
 37.01 IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE? NO 37.01

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 THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COL. 2 THE HOME OFFICE CHAIN NUMBER. (SEE INST.) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER THE NAME AND ADDRESS OF THE HOME OFFICE ON LINES 40.01-40.03. 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? YES 42
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? YES 42.01
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? YES 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? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2. NO 45
 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 NHCNQ 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	N	N	N	49
50 HOME HEALTH AGENCY	N	N	N	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: 54
 PREMIUMS: 226734 PAID LOSSES: AND/OR SELF INSURANCE:
 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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

		DATE 0 / /	Y/N 1 NO	LIMIT 2 0.00	Y/N 3 NO	FEE\$ 4
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.	/ /	NO	0.00	NO	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
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? 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)		NO			60
60.01	IF LINE 60 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 '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.)					60.01
MULTICAMPUS						
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. 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.		NO			61
	COUNTY:		STATE:	ZIP CODE	CBSA	FTE/ CAMPUS
	1		2	3	4	5
SETTLEMENT DATA						
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)		NO			63

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS
	TITLE	TITLE	TITLE		
	V 12	XVIII 13	XIX 14	15	
1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		672	85	985	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		672	85	985	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	2	3	4	5	6	
1 TOTAL SALARIES	7313858						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	67907						8.01
OTHER WAGES & RELATED COSTS							
9 CONTRACT LABOR							9
9.01 PHARMACY SERVICES UNDER CONTRACT							9.01
9.02 LABORATORY SERVICES UNDER CONTRACT							9.02
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
WAGE-RELATED COSTS							
13 WAGE RELATED COSTS (CORE)						CMS 339	13
14 WAGE RELATED COSTS (OTHER)						CMS 339	14
15 EXCLUDED AREAS						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)							19.01
20 INTERNS & RESIDENTS (IN APPR PGM)						CMS 339	20
OVERHEAD COSTS - DIRECT SALARIES							
21 EMPLOYEE BENEFITS	96823						21
22 ADMINISTRATIVE & GENERAL	935226						22
22.01 ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23 MAINTENANCE & REPAIRS							23
24 OPERATION OF PLANT	267254						24
25 LAUNDRY & LINEN SERVICE	31381						25
26 HOUSEKEEPING	141203						26
26.01 HOUSEKEEPING UNDER CONTRACT							26.01
27 DIETARY	242239	-185022					27
27.01 DIETARY UNDER CONTRACT							27.01
28 CAFETERIA		185022					28
29 MAINTENANCE OF PERSONNEL							29
30 NURSING ADMINISTRATION	106134						30
31 CENTRAL SERVICES AND SUPPLY	92765	-12766					31
32 PHARMACY	42782						32
33 MEDICAL RECORDS & MEDICAL RECORDS LIBR	219871						33
34 SOCIAL SERVICE	42670						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)
		A-6	3	4	5
1 NET SALARIES	7313858		7313858		
2 EXCLUDED AREA SALARIES	67907		67907		
3 SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7245951		7245951		
4 SUBTOTAL OTHER WAGES & REL COSTS					
5 SUBTOTAL WAGE-RELATED COSTS					
6 TOTAL (SUM OF LINES 3 THRU 5)	7245951		7245951		
7 NET SALARIES					
8 EXCLUDED AREA SALARIES					
9 SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)					
10 SUBTOTAL OTHER WAGES & REL COSTS					
11 SUBTOTAL WAGE-RELATED COSTS					
12 TOTAL (SUM OF LINES 9 THRU 11)					
13 TOTAL OVERHEAD COSTS	2218348	-12766	2205582		

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
2 UNDUPLICATED CENSUS COUNT		127.00		35.00	157.00	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	
.00				
3 ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)		1.00	1.00	3
4 DIRECTORS AND ASSISTANT DIRECTOR(S)				4
5 OTHER ADMINISTRATIVE PERSONNEL				5
6 DIRECT NURSING SERVICE		.91	.91	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				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		99140	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

RHC I
 COMPONENT NO: 14-3413

WORKSHEET S-8

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

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

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)

0	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12 CLINIC														

(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: - V 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		475085	475085	166768	641853		641853	3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		783505	783505	727566	1511071	-488	1510583	4
5	0500 EMPLOYEE BENEFITS	96823	1554710	1651533		1651533	-59894	1591639	5
6.01	0662 ADMINISTRATIVE & ACCOUNTING	365578	2742778	3108356	-171328	2937028	-1969648	967380	6.01
6.02	0661 BUSINESS SERVICES	569648	371169	940817	-5785	935032	-26884	908148	6.02
7	0700 MAINTENANCE & REPAIRS								7
8	0800 OPERATION OF PLANT	267254	642258	909512	-28561	880951	-1842	879109	8
9	0900 LAUNDRY & LINEN SERVICE	31381	26563	57944		57944		57944	9
10	1000 HOUSEKEEPING	141203	89442	230645		230645		230645	10
11	1100 DIETARY	242239	378857	621096	-475251	145845	-27691	118154	11
12	1200 CAFETERIA				474393	474393	-122651	351742	12
13	1300 MAINTENANCE OF PERSONNEL								13
14	1400 NURSING ADMINISTRATION	106134	29385	135519		135519		135519	14
15	1500 CENTRAL SERVICES & SUPPLY								15
15.01	1501 PURCHASING	79999	14484	94483	-88	94395		94395	15.01
15.02	1502 CENTRAL SERVICES & SUPPLY	12766	524825	537591	-537591				15.02
16	1600 PHARMACY	42782	1029205	1071987	-16908	1055079	-962	1054117	16
17	1700 MEDICAL RECORDS & LIBRARY	219871	172221	392092		392092	-14	392078	17
18	1800 SOCIAL SERVICE	42670	5197	47867		47867		47867	18
20	2000 NONPHYSICIAN ANESTHETISTS				448031	448031	-448031		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	1602788	209944	1812732	-574	1812158		1812158	25
26	2600 INTENSIVE CARE UNIT								26
	ANCILLARY SERVICE COST CENTERS								
37	3700 OPERATING ROOM	595407	384310	979717	-99035	880682	-24000	856682	37
40	4000 ANESTHESIOLOGY	196416	303832	500248	-500248				40
41	4100 RADIOLOGY-DIAGNOSTIC	663789	1157040	1820829	-540134	1280695		1280695	41
44	4400 LABORATORY	526127	990315	1516442	-112	1516330		1516330	44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49	4900 RESPIRATORY THERAPY	266026	247963	513989	-13275	500714	-73968	426746	49
50	5000 PHYSICAL THERAPY		814609	814609	-420	814189	-1284	812905	50
51	5100 OCCUPATIONAL THERAPY								51
52	5200 SPEECH PATHOLOGY								52
53	5300 ELECTROCARDIOLOGY	52762	67655	120417		120417	-56815	63602	53
55	5500 MEDICAL SUPPLIES CHARGED TO PAT				537591	537591		537591	55
56	5600 DRUGS CHARGED TO PATIENTS				36699	36699		36699	56
	OUTPATIENT SERVICE COST CENTERS								
60	6000 CLINIC	118194	17392	135586		135586		135586	60
60.01	6001 SALEM MEDICAL CLINIC								60.01
61	6100 EMERGENCY	766388	1937311	2703699	-297395	2406304	-604059	1802245	61
62	6200 OBSERVATION BEDS (NON-DISTINCT								62
63.50	6310 PHOTOS RHC	239706	26877	266583	295747	562330		562330	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	17368	11084	28452	-90	28362		28362	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	7263319	15008016	22271335		22271335	-3418231	18853104	95
	NONREIMBURSABLE COST CENTERS								
96	9600 GIFT, FLOWER, COFFEE SHOP & CAN	10319	15528	25847		25847		25847	96
98	9800 PHYSICIANS' PRIVATE OFFICES	40220	5071	45291		45291		45291	98
98.01	9801 TEMPORARILY IDLE SPACE								98.01
101	TOTAL	7313858	15028615	22342473		22342473	-3418231	18924242	101

RECLASSIFICATIONS

1	EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----				2
			COST CENTER	LINE #	SALARY	OTHER	
3			2	3	4	5	
1	TO RECLASS CAFETERIA COST	A	CAFETERIA	12	185022	289371	1
2	TO RECLASS SUPPLY COST	B	MEDICAL SUPPLIES CHARGED TO P	55	12766	524825	2
3	TO RECLASS RENTALS	C	NEW CAP REL COSTS-MVBLE EQUIP	4		727566	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		C					13
14		C					14
15		C					15
16		C					16
17	TO RECLASS CRNA COST	D	NONPHYSICIAN ANESTHETISTS	20		448031	17
18	TO RECLASS REMAINING ANESTHESIA SUPP	E	OPERATING ROOM	37		52217	18
19	TO RECLASS PHYSICIAN PORTION FOR RHC	G	PHOTOS RHC	63.50		295747	19
20	TO RECLASS OTHER CAPITAL COSTS	H	NEW CAP REL COSTS-BLDG & FIXT	3		63031	20
21	TO RECLASS RESP DRUGS CHGD TO PT	I	DRUGS CHARGED TO PATIENTS	56		36699	21
22	TO RECLASS ADMIN EXPENSES FOR RHC	J					22
23	TO RECLASS INTEREST EXPENSE	K	NEW CAP REL COSTS-BLDG & FIXT	3		103737	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				197788	2541224	36

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE			WKST A-7 REF.
			LINE #	SALARY	OTHER	
1	1	6	7	8	9	10
1 TO RECLASS CAFETERIA COST	A	DIETARY	11	185022	289371	1
2 TO RECLASS SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	15.02	12766	524825	2
3 TO RECLASS RENTALS	C	ADULTS & PEDIATRICS	25		574	10 3
4	C	HOME HEALTH AGENCY	71		90	4
5	C	OPERATING ROOM	37		151252	5
6	C	DIETARY	11		858	6
7	C	PURCHASING	15.01		88	7
8	C	PHARMACY	16		16908	8
9	C	LABORATORY	44		112	9
10	C	RADIOLOGY-DIAGNOSTIC	41		503435	10
11	C	RESPIRATORY THERAPY	49		13275	11
12	C	PHYSICAL THERAPY	50		420	12
13	C	OPERATION OF PLANT	8		28561	13
14	C	ADMINISTRATIVE & ACCOUNTING	6.01		4560	14
15	C	BUSINESS SERVICES	6.02		5785	15
16	C	EMERGENCY	61		1648	16
17 TO RECLASS CRNA COST	D	ANESTHESIOLOGY	40		448031	17
18 TO RECLASS REMAINING ANESTHESIA S	E	ANESTHESIOLOGY	40		52217	18
19 TO RECLASS PHYSICIAN PORTION FOR	G	EMERGENCY	61		295747	19
20 TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	6.01		63031	14 20
21 TO RECLASS RESP DRUGS CHGD TO PT	I	RADIOLOGY-DIAGNOSTIC	41		36699	21
22 TO RECLASS ADMIN EXPENSES FOR RHC	J					22
23 TO RECLASS INTEREST EXPENSE	K	ADMINISTRATIVE & ACCOUNTING	6.01		103737	14 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				197788	2541224	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	61162					61162		1
2 LAND IMPROVEMENTS	830484	3803		3803		834287		2
3 BUILDINGS AND FIXTURES	15798884	4190846		4190846	362371	19627359		3
4 BUILDING IMPROVEMENTS								4
5 FIXED EQUIPMENT	1514596				4347	1510249		5
6 MOVABLE EQUIPMENT	7961926	744498		744498	338110	8368314		6
7 SUBTOTAL	26167052	4939147		4939147	704828	30401371		7
8 RECONCILING ITEMS								8
9 TOTAL	26167052	4939147		4939147	704828	30401371		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	475085					166768	641853 3
4 NEW CAP REL COSTS-MVBLE EQUIP	783505	727566				-488	1510583 4
5 TOTAL	1258590	727566				166280	2152436 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	475085						475085 3
4 NEW CAP REL COSTS-MVBLE EQUIP	783505						783505 4
5 TOTAL	1258590						1258590 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	-43980	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	-1734	ADMINISTRATIVE & ACCOUNTING	6.01	9
10 TELEVISION AND RADIO SERVICE	A	-1842	OPERATION OF PLANT	8	10
11 PARKING LOT					11
12 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-758842			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	-122651	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	B	-962	PHARMACY	16	19
20 SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-14	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	-448031	NONPHYSICIAN ANESTHETISTS	20	33
34 PHYSICIANS' ASSISTANT					34
35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		OCCUPATIONAL THERAPY	51	35
36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST A-8-4		SPEECH PATHOLOGY	52	36
37 PROVISION FOR BAD DEBTS	A	-1804993	ADMINISTRATIVE & ACCOUNTING	6.01	37
38 DIETARY REVENUE	B	-27691	DIETARY	11	38
39 BUS OFFICE COSTS ASSOC W/ PHYS CH	A	-26884	BUSINESS SERVICES	6.02	39
40 TELEPHONE	A	-488	NEW CAP REL COSTS-MVBLE EQUIP	4	40
41 PHYSICIAN RECRUITMENT	A	-106395	ADMINISTRATIVE & ACCOUNTING	6.01	41
42 OTHER REVENUE	B	-121	ADMINISTRATIVE & ACCOUNTING	6.01	42
43 LOBBYING PORTION OF DUES	A	-11424	ADMINISTRATIVE & ACCOUNTING	6.01	43
44 MARKETING	A	-59894	EMPLOYEE BENEFITS	5	44
45 OTHER REVENUE	B	-721	ADMINISTRATIVE & ACCOUNTING	6.01	45
46 SPOUSE MEAL COST	A	-280	ADMINISTRATIVE & ACCOUNTING	6.01	46
47 ATHLETIC TRAINER	A	-1284	PHYSICAL THERAPY	50	47
48					48
49					49
50 TOTAL		-3418231			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 ADJ- USTMENTS	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:

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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
LINE NO.	2	3	4	5	6	7	8	9
1 37	OPERATING ROOM		OR	24000	24000			
2 44	LABORATORY		LABORATORY	38500		38500		
3 49	RESPIRATORY THERAPY		RESPIRATORY THERAPY	73398	73398			
4 49	RESPIRATORY THERAPY		RESPIRATORY THERAPY	570	570			
5 53	ELECTROCARDIOLOGY		ELECTROCARDIOLOGY	56815	56815			
6 61	EMERGENCY		EMERGENCY	1512796	604059	908736		
7 63.50	PHOTOS RHC		RHC					
101	TOTAL			1706079	758842	947236		

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS I & II

[XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					40	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					600	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		1870.00				9
10	AHSEA		65.94				10
11	STANDARD TRAVEL ALLOWANCE	32.97	32.97				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					123308	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					123308	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					123308	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					123308	23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-4
PARTS III & IV

[XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE	
24 THERAPISTS	24
25 ASSISTANTS	25
26 SUBTOTAL	26
27 STANDARD TRAVEL EXPENSE	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29 THERAPISTS	29
30 ASSISTANTS	30
31 SUBTOTAL	31
32 OPTIONAL TRAVEL EXPENSE	32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE

36 THERAPISTS	36
37 ASSISTANTS	37
38 SUBTOTAL	38
39 STANDARD TRAVEL EXPENSE	39

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

40 THERAPISTS	40
41 ASSISTANTS	41
42 SUBTOTAL	42
43 OPTIONAL TRAVEL EXPENSE	43

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-4
 PARTS V,VI & VII

[XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5		
47						OVERTIME HOURS WORKED DURING REPORTING PERIOD	47
48						OVERTIME RATE	48
49						TOTAL OVERTIME	49
CALCULATION OF LIMIT							
50						PERCENTAGE OF OVERTIME HOURS BY CATEGORY	50
51						ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50	51
DETERMINATION OF OVERTIME ALLOWANCE							
52						ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT	52
53						OVERTIME COST LIMITATION	53
54						MAXIMUM OVERTIME COST	54
55						PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA	55
56						OVERTIME ALLOWANCE	56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					123308	SALARY EQUIVALENCY AMOUNT	57
58						TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	58
59						TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	59
60						OVERTIME ALLOWANCE	60
61						EQUIPMENT COST	61
62						SUPPLIES	62
63					123308	TOTAL ALLOWANCE	63
64					77022	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	64
65						EXCESS OVER LIMITATION	65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-4
PARTS V,VI & VII

[XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	77022	66
67	TOTAL COST	77022	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS I & II

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		4092.00		4277.00		9
10	AHSEA		69.57		50.54		10
11	STANDARD TRAVEL ALLOWANCE	34.79	34.79				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					284680	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					284680	17
18	AIDES					216160	18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					500840	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					500840	23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-4
PARTS III & IV

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE	
24 THERAPISTS	24
25 ASSISTANTS	25
26 SUBTOTAL	26
27 STANDARD TRAVEL EXPENSE	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29 THERAPISTS	29
30 ASSISTANTS	30
31 SUBTOTAL	31
32 OPTIONAL TRAVEL EXPENSE	32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE

36 THERAPISTS	36
37 ASSISTANTS	37
38 SUBTOTAL	38
39 STANDARD TRAVEL EXPENSE	39

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

40 THERAPISTS	40
41 ASSISTANTS	41
42 SUBTOTAL	42
43 OPTIONAL TRAVEL EXPENSE	43

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS V,VI & VII

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5	
47						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					500840	57
58						58
59						59
60						60
61						61
62						62
63					500840	63
64					349623	64
65						65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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WORKSHEET A-8-4
PARTS V,VI & VII

[] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	349623	66
67	TOTAL COST	349623	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2009 TO 03/31/2010

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

VERSION: 2010.02
 08/16/2010 10:24

REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS I & II

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					14	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					210	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		79.25				9
10	AHSEA		63.36				10
11	STANDARD TRAVEL ALLOWANCE	31.68	31.68				11
12	NO OF TRAVEL HRS (PROV SITE)						12
12.01	NO OF TRAVEL HRS (OFFSITE)						12.01
13	MILES DRIVEN (PROV SITE)						13
13.01	MILES DRIVEN (OFFSITE)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS						14
15	THERAPISTS					5021	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					5021	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					5021	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					63.36	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					13306	22
23	TOTAL SALARY EQUIVALENCY					13306	23

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS III & IV

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE

STANDARD TRAVEL ALLOWANCE	
24 THERAPISTS	24
25 ASSISTANTS	25
26 SUBTOTAL	26
27 STANDARD TRAVEL EXPENSE	27
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	28

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

29 THERAPISTS	29
30 ASSISTANTS	30
31 SUBTOTAL	31
32 OPTIONAL TRAVEL EXPENSE	32
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	33
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	35

PART IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

STANDARD TRAVEL EXPENSE

36 THERAPISTS	36
37 ASSISTANTS	37
38 SUBTOTAL	38
39 STANDARD TRAVEL EXPENSE	39

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

40 THERAPISTS	40
41 ASSISTANTS	41
42 SUBTOTAL	42
43 OPTIONAL TRAVEL EXPENSE	43

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	44
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	46

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2009 TO 03/31/2010

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

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
 PARTS V,VI & VII

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TRAINEES 4	TOTAL 5		
47						OVERTIME HOURS WORKED DURING REPORTING PERIOD	47
48						OVERTIME RATE	48
49						TOTAL OVERTIME	49
CALCULATION OF LIMIT							
50						PERCENTAGE OF OVERTIME HOURS BY CATEGORY	50
51						ALLOCATION OF PROVIDER'S STANDARD WORKYEAR FOR ONE FULL TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50	51
DETERMINATION OF OVERTIME ALLOWANCE							
52						ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT	52
53						OVERTIME COST LIMITATION	53
54						MAXIMUM OVERTIME COST	54
55						PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA	55
56						OVERTIME ALLOWANCE	56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					13306	SALARY EQUIVALENCY AMOUNT	57
58						TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE	58
59						TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES	59
60						OVERTIME ALLOWANCE	60
61						EQUIPMENT COST	61
62						SUPPLIES	62
63					13306	TOTAL ALLOWANCE	63
64					4953	TOTAL COST OF OUTSIDE SUPPLIER SERVICES	64
65						EXCESS OVER LIMITATION	65

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-4
PARTS V,VI & VII

[] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [XX] SPEECH PATHOLOGY

PART VII - ALLOCATION OF THERAPY EXCESS COST OVER LIMITATION FOR NONSHARED THERAPY DEPARTMENT SERVICES

66	COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL	4953	66
67	TOTAL COST	4953	67
68	RATIO OF COST OF OUTSIDE SUPPLIER SERVICES TO TOTAL COST - HOSPITAL	1.000000	68
69	EXCESS OF COST OVER LIMITATION - HOSPITAL	0	69
70	TOTAL EXCESS OF COST OVER LIMITATION	0	70

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	641853	641853							3
4 NEW CAP REL COSTS-MVBLE EQUIP	1510583		1510583						4
5 EMPLOYEE BENEFITS	1591639	2998	695	1595332					5
6.01 ADMINISTRATIVE & ACCOUNTING	967380	143168	10664	80811	1202023	1202023			6.01
6.02 BUSINESS SERVICES	908148	37367	136084	125921	1207520	81901	1289421		6.02
7 MAINTENANCE & REPAIRS									7
8 OPERATION OF PLANT	879109	44711	44005	59077	1026902	69651		1096553	8
9 LAUNDRY & LINEN SERVICE	57944	7411	2783	6937	75075	5092		19648	9
10 HOUSEKEEPING	230645	6459		31213	268317	18199		17125	10
11 DIETARY	118154	22697	6204	12648	159703	10832		60173	11
12 CAFETERIA	351742			40899	392641	26631			12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	135519	10039	4911	23461	173930	11797		26614	14
15 CENTRAL SERVICES & SUPPLY									15
15.01 PURCHASING	94395	11285	508	17684	123872	8402		29919	15.01
15.02 CENTRAL SERVICES & SUPPLY									15.02
16 PHARMACY	1054117	6485	17283	9457	1087342	73750		17192	16
17 MEDICAL RECORDS & LIBRARY	392078	23311	26751	48603	490743	33285		61803	17
18 SOCIAL SERVICE	47867			9432	57299	3886			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	1812158	49225	61767	354298	2277448	154465	77591	130505	25
26 INTENSIVE CARE UNIT									26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	856682	51642	237560	175033	1320917	89593	80323	136913	37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC	1280695	28878	812527	146731	2268831	153886	428459	76561	41
44 LABORATORY	1516330	20785	69614	116301	1723030	116866	298010	55105	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	426746	15243	26950	58805	527744	35795	71419	40413	49
50 PHYSICAL THERAPY	812905	26537	5490		844932	57308	59819	70354	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY	63602		7429	11663	82694	5609	18244		53
55 MEDICAL SUPPLIES CHARGED TO PAT	537591	8085	502	2822	549000	37236	54090	21434	55
56 DRUGS CHARGED TO PATIENTS	36699				36699	2489	81568		56
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC	135586	3706	7285	26127	172704	11714	9519	9824	60
60.01 SALEM MEDICAL CLINIC									60.01
61 EMERGENCY	1802245	28844	21115	169411	2021615	137118	96787	76472	61
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 PHOTOS RHC	562330	8279	423	52987	624019	42325	13592	21948	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	28362	1853	3291	3839	37345	2533		4912	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	18853104	559008	1503841	1584160	18752345	1190363	1289421	876915	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN	25847	3242		2281	31370	2128		8596	96
98 PHYSICIANS' PRIVATE OFFICES	45291	22638	6742	8891	83562	5668		60017	98
98.01 TEMPORARILY IDLE SPACE		56965			56965	3864		151025	98.01
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	18924242	641853	1510583	1595332	18924242	1202023	1289421	1096553	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINISTRATION 14	PURCHASING 15.01	PHARMACY 16	MEDICAL RECORDS & LIBRARY 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	99815								9
10 HOUSEKEEPING	2691	306332							10
11 DIETARY	686	6483	237877						11
12 CAFETERIA				419272					12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION				4250	216591				14
15 CENTRAL SERVICES & SUPPLY									15
15.01 PURCHASING				6890		169083			15.01
15.02 CENTRAL SERVICES & SUPPLY									15.02
16 PHARMACY		4862		5347		925	1189418		16
17 MEDICAL RECORDS & LIBRARY		8374		24371		968		619544	17
18 SOCIAL SERVICE				2605		31			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	56945	113727	237877	122916	100162	11818		249762	25
26 INTENSIVE CARE UNIT									26
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	13222	43762		40481	50093	20351		38137	37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC	9150	24582		52306		23824		65432	41
44 LABORATORY		17018		47199		95191		140211	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY		6213		25502		4037		24677	49
50 PHYSICAL THERAPY	5471	12966				1336		31033	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY		6213				579		9347	53
55 MEDICAL SUPPLIES CHARGED TO PAT	322	5403		1988		561			55
56 DRUGS CHARGED TO PATIENTS							1189418		56
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC				9152		1064			60
60.01 SALEM MEDICAL CLINIC									60.01
61 EMERGENCY	11328	33767		53814	50589	5937		53093	61
62 OBSERVATION BEDS (NON-DISTINCT)									62
63.50 PHOTOS RHC				16898	15747	1136		7852	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		1081		2194		13			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	99815	284451	237877	415913	216591	167771	1189418	619544	95
NONREIMBURSABLE COST CENTERS									
96 GIFT, FLOWER, COFFEE SHOP & CAN						1178			96
98 PHYSICIANS' PRIVATE OFFICES		21881		3359		134			98
98.01 TEMPORARILY IDLE SPACE									98.01
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	99815	306332	237877	419272	216591	169083	1189418	619544	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

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	63821			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
25 INPATIENT ROUTINE SERV COST CENTERS				
ADULTS & PEDIATRICS	63821	3597037		3597037
26 INTENSIVE CARE UNIT				25
ANCILLARY SERVICE COST CENTERS				26
37 OPERATING ROOM		1833792		1833792
40 ANESTHESIOLOGY				37
41 RADIOLOGY-DIAGNOSTIC		3103031		40
44 LABORATORY		2492630		41
46.30 BLOOD CLOTTING FACTORS ADMIN CO				44
49 RESPIRATORY THERAPY		735800		46.30
50 PHYSICAL THERAPY		1083219		49
51 OCCUPATIONAL THERAPY				50
52 SPEECH PATHOLOGY				51
53 ELECTROCARDIOLOGY		122686		52
55 MEDICAL SUPPLIES CHARGED TO PAT		670034		53
56 DRUGS CHARGED TO PATIENTS		1310174		55
OUTPATIENT SERVICE COST CENTERS				56
60 CLINIC		213977		213977
60.01 SALEM MEDICAL CLINIC				60
61 EMERGENCY		2540520		60.01
62 OBSERVATION BEDS (NON-DISTINCT)				61
63.50 PHOTOS RHC		743517		62
63.60 FQHC				63.50
OTHER REIMBURSABLE COST CENTERS				63.60
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		48078		48078
SPECIAL PURPOSE COST CENTERS				71
85.01 PANCREAS ACQUISITION				85.01
85.02 INTESTINAL ACQUISITION				85.02
85.03 ISLET CELL ACQUISITION				85.03
95 SUBTOTALS	63821	18494495		18494495
NONREIMBURSABLE COST CENTERS				95
96 GIFT, FLOWER, COFFEE SHOP & CAN		43272		43272
98 PHYSICIANS' PRIVATE OFFICES		174621		174621
98.01 TEMPORARILY IDLE SPACE		211854		211854
101 CROSS FOOT ADJUSTMENTS				101
102 NEGATIVE COST CENTER				102
103 TOTAL	63821	18924242		18924242

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	EMPLOYEE BENEFITS 5	ADMINISTRA TIVE & ACC OUNTING 6.01	BUSINESS S ERVICES 6.02	OPERATION OF PLANT 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									3
4	NEW CAP REL COSTS-MVBLE EQUIP									4
5	EMPLOYEE BENEFITS		2998	695	3693	3693				5
6.01	ADMINISTRATIVE & ACCOUNTING	143168		10664	153832	187	154019			6.01
6.02	BUSINESS SERVICES	37367		136084	173451	292	10495	184238		6.02
7	MAINTENANCE & REPAIRS									7
8	OPERATION OF PLANT		44711	44005	88716	137	8925		97778	8
9	LAUNDRY & LINEN SERVICE		7411	2783	10194	16	652		1752	9
10	HOUSEKEEPING		6459		6459	72	2332		1527	10
11	DIETARY		22697	6204	28901	29	1388		5366	11
12	CAFETERIA					95	3412			12
13	MAINTENANCE OF PERSONNEL									13
14	NURSING ADMINISTRATION		10039	4911	14950	54	1512		2373	14
15	CENTRAL SERVICES & SUPPLY									15
15.01	PURCHASING		11285	508	11793	41	1077		2668	15.01
15.02	CENTRAL SERVICES & SUPPLY									15.02
16	PHARMACY		6485	17283	23768	22	9450		1533	16
17	MEDICAL RECORDS & LIBRARY		23311	26751	50062	113	4265		5511	17
18	SOCIAL SERVICE					22	498			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		49225	61767	110992	818	19788	11086	11637	25
26	INTENSIVE CARE UNIT									26
ANCILLARY SERVICE COST CENTERS										
37	OPERATING ROOM		51642	237560	289202	405	11480	11476	12208	37
40	ANESTHESIOLOGY									40
41	RADIOLOGY-DIAGNOSTIC		28878	812527	841405	340	19718	61226	6827	41
44	LABORATORY		20785	69614	90399	269	14975	42579	4914	44
46.30	BLOOD CLOTTING FACTORS ADMIN CO									46.30
49	RESPIRATORY THERAPY		15243	26950	42193	136	4587	10204	3604	49
50	PHYSICAL THERAPY		26537	5490	32027		7343	8547	6273	50
51	OCCUPATIONAL THERAPY									51
52	SPEECH PATHOLOGY									52
53	ELECTROCARDIOLOGY			7429	7429	27	719	2607		53
55	MEDICAL SUPPLIES CHARGED TO PAT		8085	502	8587	7	4771	7728	1911	55
56	DRUGS CHARGED TO PATIENTS						319	11654		56
OUTPATIENT SERVICE COST CENTERS										
60	CLINIC		3706	7285	10991	61	1501	1360	876	60
60.01	SALEM MEDICAL CLINIC									60.01
61	EMERGENCY		28844	21115	49959	392	17570	13829	6819	61
62	OBSERVATION BEDS (NON-DISTINCT									62
63.50	PHOTOS RHC		8279	423	8702	123	5423	1942	1957	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		1853	3291	5144	9	325		438	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		559008	1503841	2062849	3667	152525	184238	78194	95
NONREIMBURSABLE COST CENTERS										
96	GIFT, FLOWER, COFFEE SHOP & CAN		3242		3242	5	273		767	96
98	PHYSICIANS' PRIVATE OFFICES		22638	6742	29380	21	726		5352	98
98.01	TEMPORARILY IDLE SPACE		56965		56965		495		13465	98.01
101	CROSS FOOT ADJUSTMENTS									101
102	NEGATIVE COST CENTER									102
103	TOTAL		641853	1510583	2152436	3693	154019	184238	97778	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

COST CENTER DESCRIPTION	LAUNDRY & LINEN SERVICE 9	HOUSE-KEEPING 10	DIETARY 11	CAFETERIA 12	NURSING ADMINISTRATION 14	PURCHASING 15.01	PHARMACY 16	MEDICAL RECORDS & LIBRARY 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	12614							9
10 HOUSEKEEPING	340	10730						10
11 DIETARY	87	227	35998					11
12 CAFETERIA				3507				12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION				36	18925			14
15 CENTRAL SERVICES & SUPPLY								15
15.01 PURCHASING				58		15637		15.01
15.02 CENTRAL SERVICES & SUPPLY								15.02
16 PHARMACY		170		45		86	35074	16
17 MEDICAL RECORDS & LIBRARY		293		204		90		60538
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	7196	3984	35998	1026	8752	1093		24405
26 INTENSIVE CARE UNIT								25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	1671	1533		339	4377	1882		3727
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC	1156	861		438		2203		6394
44 LABORATORY		596		395		8803		13701
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY		218		213		373		2411
50 PHYSICAL THERAPY	691	454				124		3032
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY		218				54		913
55 MEDICAL SUPPLIES CHARGED TO PAT	41	189		17		52		55
56 DRUGS CHARGED TO PATIENTS							35074	56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC				77		98		60
60.01 SALEM MEDICAL CLINIC								60.01
61 EMERGENCY	1432	1183		450	4420	549		5188
62 OBSERVATION BEDS (NON-DISTINCT)								62
63.50 PHOTOS RHC				141	1376	105		767
63.60 FQHC								63.50
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		38		18		1		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	12614	9964	35998	3479	18925	15516	35074	60538
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & CAN						109		96
98 PHYSICIANS' PRIVATE OFFICES		766		28		12		98
98.01 TEMPORARILY IDLE SPACE								98.01
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	12614	10730	35998	3507	18925	15637	35074	60538

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	545			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	545	237320		237320
26 INTENSIVE CARE UNIT				25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM		338300		338300
40 ANESTHESIOLOGY				37
41 RADIOLOGY-DIAGNOSTIC		940568		940568
44 LABORATORY		176631		176631
46.30 BLOOD CLOTTING FACTORS ADMIN CO				41
49 RESPIRATORY THERAPY		63939		63939
50 PHYSICAL THERAPY		58491		58491
51 OCCUPATIONAL THERAPY				44
52 SPEECH PATHOLOGY				46.30
53 ELECTROCARDIOLOGY		11967		11967
55 MEDICAL SUPPLIES CHARGED TO PAT		23303		23303
56 DRUGS CHARGED TO PATIENTS		47047		47047
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC		14964		14964
60.01 SALEM MEDICAL CLINIC				60
61 EMERGENCY		101791		101791
62 OBSERVATION BEDS (NON-DISTINCT)				61
63.50 PHOTOS RHC		20536		20536
63.60 FQHC				62
OTHER REIMBURSABLE COST CENTERS				
69.10 CMHC				63.50
69.20 OUTPATIENT PHYSICAL THERAPY				63.60
69.30 OUTPATIENT OCCUPATIONAL THERAPY				69.10
69.40 OUTPATIENT SPEECH PATHOLOGY				69.20
71 HOME HEALTH AGENCY		5973		5973
SPECIAL PURPOSE COST CENTERS				
85.01 PANCREAS ACQUISITION				69.30
85.02 INTESTINAL ACQUISITION				69.40
85.03 ISLET CELL ACQUISITION				71
95 SUBTOTALS	545	2040830		2040830
NONREIMBURSABLE COST CENTERS				
96 GIFT, FLOWER, COFFEE SHOP & CAN		4396		4396
98 PHYSICIANS' PRIVATE OFFICES		36285		36285
98.01 TEMPORARILY IDLE SPACE		70925		70925
101 CROSS FOOT ADJUSTMENTS				96
102 NEGATIVE COST CENTER				98
103 TOTAL	545	2152436		2152436

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 GROSS CHAR GES	OF PLANT SQUARE FEET	
	3	4	5	6A.01	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	76214							3
4 NEW CAP REL COSTS-MVBLE EQUIP		1511069						4
5 EMPLOYEE BENEFITS	356	695	7217034					5
6.01 ADMINISTRATIVE & ACCOUNTING	17000	10667	365578	-1202023	17722219			6.01
6.02 BUSINESS SERVICES	4437	136128	569648		1207520	43936629		6.02
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT	5309	44019	267254		1026902		49112	8
9 LAUNDRY & LINEN SERVICE	880	2784	31381		75075		880	9
10 HOUSEKEEPING	767		141203		268317		767	10
11 DIETARY	2695	6206	57217		159703		2695	11
12 CAFETERIA			185022		392641			12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION	1192	4913	106134		173930		1192	14
15 CENTRAL SERVICES & SUPPLY								15
15.01 PURCHASING	1340	508	79999		123872		1340	15.01
15.02 CENTRAL SERVICES & SUPPLY								15.02
16 PHARMACY	770	17289	42782		1087342		770	16
17 MEDICAL RECORDS & LIBRARY	2768	26760	219871		490743		2768	17
18 SOCIAL SERVICE			42670		57299			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	5845	61787	1602788		2277448	2643932	5845	25
26 INTENSIVE CARE UNIT								26
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	6132	237637	791823		1320917	2737002	6132	37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC	3429	812788	663789		2268831	14599323	3429	41
44 LABORATORY	2468	69636	526127		1723030	10154696	2468	44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY	1810	26959	266025		527744	2433613	1810	49
50 PHYSICAL THERAPY	3151	5492			844932	2038346	3151	50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY		7431	52762		82694	621659		53
55 MEDICAL SUPPLIES CHARGED TO P	960	502	12766		549000	1843110	960	55
56 DRUGS CHARGED TO PATIENTS					36699	2779442		56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC	440	7287	118194		172704	324346	440	60
60.01 SALEM MEDICAL CLINIC								60.01
61 EMERGENCY	3425	21122	766388		2021615	3298015	3425	61
62 OBSERVATION BEDS (NON-DISTINC								62
63.50 PHOTOS RHC	983	423	239706		624019	463145	983	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	220	3292	17368		37345		220	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	66377	1504325	7166495	-1202023	17550322	43936629	39275	95
NONREIMBURSABLE COST CENTERS								
96 GIFT, FLOWER, COFFEE SHOP & C	385		10319		31370		385	96
98 PHYSICIANS' PRIVATE OFFICES	2688	6744	40220		83562		2688	98
98.01 TEMPORARILY IDLE SPACE	6764				56965		6764	98.01

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	641853	1510583	1595332		1202023	1289421	1096553	103
104 UNIT COST MULT-WS B PT I		.999678				.029347		104
104 UNIT COST MULT-WS B PT I	8.421720		.221051		.067826		22.327598	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			3693		154019	184238	97778	107
108 UNIT COST MULT-WS B PT III						.004193		108
108 UNIT COST MULT-WS B PT III			.000512		.008691		1.990919	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	HOURS OF SERVICE	MEALS SERVED	MEALS SERVED	DIRECT NRSING HRS	COSTED REQUIS.	COSTED REQ UIS.	COSTED REQUIS.
	9	10	11	12	14	15.01	15.02	16
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	99815	306332	237877	419272	216591	169083		1189418 103
104 UNIT COST MULT-WS B PT I	4.663816		24.407654		1.548660			104
104 UNIT COST MULT-WS B PT I		270.134039		34.276651		.137140		11894.180000 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	12614	10730	35998	3507	18925	15637		35074 107
108 UNIT COST MULT-WS B PT III	.589384		3.693618		.135317			108
108 UNIT COST MULT-WS B PT III		9.462081		.286707		.012683		350.740000 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	1657		17
18 SOCIAL SERVICE		3670	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	668	3670	25
26 INTENSIVE CARE UNIT			26
ANCILLARY SERVICE COST CENTERS			
37 OPERATING ROOM	102		37
40 ANESTHESIOLOGY			40
41 RADIOLOGY-DIAGNOSTIC	175		41
44 LABORATORY	375		44
46.30 BLOOD CLOTTING FACTORS ADMIN			46.30
49 RESPIRATORY THERAPY	66		49
50 PHYSICAL THERAPY	83		50
51 OCCUPATIONAL THERAPY			51
52 SPEECH PATHOLOGY			52
53 ELECTROCARDIOLOGY	25		53
55 MEDICAL SUPPLIES CHARGED TO P			55
56 DRUGS CHARGED TO PATIENTS			56
OUTPATIENT SERVICE COST CENTERS			
60 CLINIC			60
60.01 SALEM MEDICAL CLINIC			60.01
61 EMERGENCY	142		61
62 OBSERVATION BEDS (NON-DISTINC			62
63.50 PHOTOS RHC	21		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	1657	3670	95
NONREIMBURSABLE COST CENTERS			
96 GIFT, FLOWER, COFFEE SHOP & C			96
98 PHYSICIANS' PRIVATE OFFICES			98
98.01 TEMPORARILY IDLE SPACE			98.01

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	619544	63821	103
104 UNIT COST MULT-WS B PT I	373.894991		104
104 UNIT COST MULT-WS B PT I		17.389918	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	60538	545	107
108 UNIT COST MULT-WS B PT III	36.534701		108
108 UNIT COST MULT-WS B PT III		.148501	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	3597037		3597037		3597037	25
26 INTENSIVE CARE UNIT						26
26 ANCILLARY SERVICE COST CENTERS						26
37 OPERATING ROOM	1833792		1833792		1833792	37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	3103031		3103031		3103031	41
44 LABORATORY	2492630		2492630		2492630	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	735800		735800		735800	49
50 PHYSICAL THERAPY	1083219		1083219		1083219	50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	122686		122686		122686	53
55 MEDICAL SUPPLIES CHARGED TO	670034		670034		670034	55
56 DRUGS CHARGED TO PATIENTS	1310174		1310174		1310174	56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	213977		213977		213977	60
60.01 SALEM MEDICAL CLINIC						60.01
61 EMERGENCY	2540520		2540520		2540520	61
62 OBSERVATION BEDS (NON-DISTI	294934		294934		294934	62
63.50 PHOTOS RHC	743517		743517		743517	63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	18741351		18741351		18741351	101
102 LESS OBSERVATION BEDS	294934		294934		294934	102
103 TOTAL	18446417		18446417		18446417	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			
INPATIENT ROUTINE SERV COST CENTERS						
25 ADULTS & PEDIATRICS	2643932		2643932			25
26 INTENSIVE CARE UNIT						26
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	454671	2282331	2737002	.670000	.670000	.670000 37
40 ANESTHESIOLOGY						40
41 RADIOLOGY-DIAGNOSTIC	1354381	13244942	14599323	.212546	.212546	.212546 41
44 LABORATORY	1753154	8401542	10154696	.245466	.245466	.245466 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	949542	1484071	2433613	.302349	.302349	.302349 49
50 PHYSICAL THERAPY	191035	1847311	2038346	.531421	.531421	.531421 50
51 OCCUPATIONAL THERAPY						51
52 SPEECH PATHOLOGY						52
53 ELECTROCARDIOLOGY	65251	556408	621659	.197353	.197353	.197353 53
55 MEDICAL SUPPLIES CHARGED TO	904758	938352	1843110	.363534	.363534	.363534 55
56 DRUGS CHARGED TO PATIENTS	1307262	1472180	2779442	.471380	.471380	.471380 56
OUTPATIENT SERVICE COST CENTERS						
60 CLINIC	665	323681	324346	.659718	.659718	.659718 60
60.01 SALEM MEDICAL CLINIC						60.01
61 EMERGENCY	124280	3173735	3298015	.770318	.770318	.770318 61
62 OBSERVATION BEDS (NON-DISTI	600	140095	140695	2.096265	2.096265	2.096265 62
63.50 PHOTOS RHC		463145	463145	1.605365	1.605365	1.605365 63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	9749531	34327793	44077324			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	9749531	34327793	44077324			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							
OPERATING ROOM	.670000	.670000	.670000				37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	.212546	.212546	.212546				41
44 LABORATORY	.245466	.245466	.245466				44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	.302349	.302349	.302349				49
50 PHYSICAL THERAPY	.531421	.531421	.531421				50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	.197353	.197353	.197353				53
55 MEDICAL SUPPLIES CHARGED TO PAT	.363534	.363534	.363534				55
56 DRUGS CHARGED TO PATIENTS	.471380	.471380	.471380				56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC	.659718	.659718	.659718				60
60.01 SALEM MEDICAL CLINIC							60.01
61 EMERGENCY	.770318	.770318	.770318				61
62 OBSERVATION BEDS (NON-DISTINCT	2.096265	2.096265	2.096265				62
63.50 PHOTOS RHC	1.605365	1.605365	1.605365				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	
1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES		.471380	1
2 VACCINE CHARGES (OTHER THAN HEPATITIS B)			2
2.01 VACCINE CHARGES - HEPATITIS B			2.01
3 VACCINE COSTS (OTHER THAN HEPATITIS B)			3
3.01 VACCINE COSTS - HEPATITIS B			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	OTHER OUTPATIENT DIAGNOSTIC
	5	5.01	5.02	5.03	5.04	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM	1192663							37
40 ANESTHESIOLOGY								40
41 RADIOLOGY-DIAGNOSTIC	5263376							41
44 LABORATORY	3355579							44
46.30 BLOOD CLOTTING FACTORS ADMIN C								46.30
49 RESPIRATORY THERAPY	485615							49
50 PHYSICAL THERAPY	694707							50
51 OCCUPATIONAL THERAPY								51
52 SPEECH PATHOLOGY								52
53 ELECTROCARDIOLOGY	365191							53
55 MEDICAL SUPPLIES CHARGED TO PA	688212							55
56 DRUGS CHARGED TO PATIENTS	847360							56
OUTPATIENT SERVICE COST CENTERS								
60 CLINIC	165500							60
60.01 SALEM MEDICAL CLINIC								60.01
61 EMERGENCY	1168692							61
62 OBSERVATION BEDS (NON-DISTINCT	77562							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	14304457							101
102 CRNA CHARGES								102
103 PBP CLINIC LAB								103
104 NET CHARGES	14304457							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	799084						37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	1118710						41
44 LABORATORY	823681						44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	146825						49
50 PHYSICAL THERAPY	369182						50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	72072						53
55 MEDICAL SUPPLIES CHARGED TO PAT	250188						55
56 DRUGS CHARGED TO PATIENTS	399429						56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC	109183						60
60.01 SALEM MEDICAL CLINIC							60.01
61 EMERGENCY	900264						61
62 OBSERVATION BEDS (NON-DISTINCT	162591						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	5151209						101
102 CRNA CHARGES							102
103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS							103
104 NET CHARGES	5151209						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				237320	10300	227020	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				237320		227020	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	3815	213			59.51	12676	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	3815	213				12676	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 CAPITAL	NEW CAPITAL	TOTAL CHARGES	INPATIENT PROGRAM CHARGES	----	OLD CAPITAL	----	NEW CAPITAL	----
	RELATED COST	RELATED COST			RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS	
	1	2	3	4	5	6	7	8	
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM		338300	2737002	105891			.123602	13088	37
40 ANESTHESIOLOGY									40
41 RADIOLOGY-DIAGNOSTIC		940568	14599323	169138			.064425	10897	41
44 LABORATORY		176631	10154696	148153			.017394	2577	44
46.30 BLOOD CLOTTING FACTORS ADMIN									46.30
49 RESPIRATORY THERAPY		63939	2433613	46375			.026273	1218	49
50 PHYSICAL THERAPY		58491	2038346	7050			.028695	202	50
51 OCCUPATIONAL THERAPY									51
52 SPEECH PATHOLOGY									52
53 ELECTROCARDIOLOGY		11967	621659				.019250		53
55 MEDICAL SUPPLIES CHARGED TO P		23303	1843110	65902			.012643	833	55
56 DRUGS CHARGED TO PATIENTS		47047	2779442	104789			.016927	1774	56
OUTPATIENT SERVICE COST CENTERS									
60 CLINIC		14964	324346				.046136		60
60.01 SALEM MEDICAL CLINIC									60.01
61 EMERGENCY		101791	3298015	55577			.030864	1715	61
62 OBSERVATION BEDS (NON-DISTINC			140695						62
63.50 PHOTOS RHC			463145						63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
101 TOTAL		1777001	40970247	702875				32304	101

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2009 TO 03/31/2010

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

VERSION: 2010.02
 08/16/2010 10:24

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					3815		213	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					3815		213	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 1	COST 1.01	COST 2				
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
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY							53
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC							60
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		2737002			105891		37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC		14599323			169138		41
44 LABORATORY		10154696			148153		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		2433613			46375		49
50 PHYSICAL THERAPY		2038346			7050		50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY		621659					53
55 MEDICAL SUPPLIES CHARGED TO P		1843110			65902		55
56 DRUGS CHARGED TO PATIENTS		2779442			104789		56
OUTPATIENT SERVICE COST CENTERS							
60 CLINIC		324346					60
60.01 SALEM MEDICAL CLINIC							60.01
61 EMERGENCY		3298015			55577		61
62 OBSERVATION BEDS (NON-DISTINC		140695					62
63.50 PHOTOS RHC		463145					63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		40970247			702875		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
	8.01	8.02	9	9.01	9.02
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
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
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

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)	3997					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3815					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3815					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	172					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	10					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)	2591					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	172					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 [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	3597037						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	983						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	156117						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3440920						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2602234						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2602234						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.322295						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	682.11						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	3440920						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	901.94					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2336927					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	2336927					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	1565217					48
49 TOTAL PROGRAM INPATIENT COSTS	3902144					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	155134					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	155134					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 04/01/2009 TO 03/31/2010

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

VERSION: 2010.02
08/16/2010 10:24

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	327	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	901.94	84
85 OBSERVATION BED COST	294934	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)	3997					1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	3815					2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)						3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3815					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	172					6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	10					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)	213					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	3597037						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	983						24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST	156117						26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3440920						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2602234						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2602234						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.322295						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	682.11						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	3440920						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	901.94					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	192113					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	192113					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	277197					48
49 TOTAL PROGRAM INPATIENT COSTS	469310					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	12676					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	32304					51
52 TOTAL PROGRAM EXCLUDABLE COST	44980					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 04/01/2009 TO 03/31/2010

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

VERSION: 2010.02
08/16/2010 10:24

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	327	83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	901.94	84
85 OBSERVATION BED COST	294934	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	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		1918508		25
26 INTENSIVE CARE UNIT				26
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	.670000	256631	171943	37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.212546	936474	199044	41
44 LABORATORY	.245466	1166405	286313	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.302349	304498	92065	49
50 PHYSICAL THERAPY	.531421	111073	59027	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.197353	51144	10093	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.363534	822262	298920	55
56 DRUGS CHARGED TO PATIENTS	.471380	943413	444706	56
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	.659718	100	66	60
60.01 SALEM MEDICAL CLINIC				60.01
61 EMERGENCY	.770318	2313	1782	61
62 OBSERVATION BEDS (NON-DISTINCT	2.096265	600	1258	62
OTHER REIMBURSABLE COST CENTERS				
63.50 PHOTOS RHC	1.605365			63.50
63.60 FQHC				63.60
101 TOTAL		4594913	1565217	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		4594913		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	.670000			37
40 ANESTHESIOLOGY				40
41 RADIOLOGY-DIAGNOSTIC	.212546	6469	1375	41
44 LABORATORY	.245466	28004	6874	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.302349	15224	4603	49
50 PHYSICAL THERAPY	.531421	66021	35085	50
51 OCCUPATIONAL THERAPY				51
52 SPEECH PATHOLOGY				52
53 ELECTROCARDIOLOGY	.197353	550	109	53
55 MEDICAL SUPPLIES CHARGED TO PAT	.363534	15872	5770	55
56 DRUGS CHARGED TO PATIENTS	.471380	32894	15506	56
OUTPATIENT SERVICE COST CENTERS				
60 CLINIC	.659718			60
60.01 SALEM MEDICAL CLINIC				60.01
61 EMERGENCY	.770318			61
62 OBSERVATION BEDS (NON-DISTINCT	2.096265			62
OTHER REIMBURSABLE COST CENTERS				
63.50 PHOTOS RHC	1.605365			63.50
63.60 FQHC				63.60
101 TOTAL		165034	69322	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		165034		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) [FOR CR PERIODS ENDING] [ON OR AFTER 7/1/2005] [E-3,PT.VI,LN.15][PLUS LN.3.06]						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.. RES. IN INIT YRS						3.16
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 INSTR.)
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	5151209			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	5151209			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	5202721			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)	HOSPITAL (14-1345)	HOSPITAL (14-1345)
	1	1.01	1.02
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18 DEDUCTIBLES	58737		18
18.01 COINSURANCE	2190801		18.01
19 SUBTOTAL	2953183		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	2953183		23
24 PRIMARY PAYER PAYMENTS	1851		24
25 SUBTOTAL	2951332		25
REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
26 COMPOSITE RATE ESRD			26
27 BAD DEBTS	473003		27
27.01 REDUCED REIMBURSABLE BAD DEBTS	473003		27.01
27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	441351		27.02
28 SUBTOTAL	3424335		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	3424335		32
33 SEQUESTRATION ADJUSTMENT			33
34 INTERIM PAYMENTS	3613544		34
34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY)			34.01
35 BALANCE DUE PROVIDER/PROGRAM	-189209		35
36 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2			36
TO BE COMPLETED BY CONTRACTOR			
50 ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)			50
51 OUTLIER RECONILIATION AMOUNT (SEE INSTRUCT			51
52 THE RATE USED TO CALCULATE THE TIME VALUE			52
53 TIME VALUE OF MONEY (SEE INSTRUCTIONS)			53
54 TOTAL (SUM OF LINES 51 AND 53)			54

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	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3407886		3667093	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.					
PROGRAM .01	12/11/2009	202814	09/18/2009	17253	3.01
TO .02					3.02
PROVIDER .03					3.03
PROVIDER .04					3.04
TO .05					3.05
PROVIDER .50					3.50
PROVIDER .51	09/18/2009	197903	12/11/2009	70802	3.51
TO .52					3.52
PROGRAM .53					3.53
PROGRAM .54					3.54
SUBTOTAL .99		4911		-53549	3.99
4 TOTAL INTERIM PAYMENTS		3412797		3613544	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		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		192299			6.01
PROVIDER TO .02				-189209	6.02
PROGRAM					
7 TOTAL MEDICARE PROGRAM LIABILITY		3605096		3424335	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		PART B	
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		228458		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
PROVIDER .04				3.04
TO .05				3.05
PROGRAM .50	12/11/2009	50580		3.50
TO .51				3.51
PROVIDER .52				3.52
PROVIDER .53				3.53
PROGRAM .54				3.54
SUBTOTAL	.99	-50580		3.99
4 TOTAL INTERIM PAYMENTS		177878		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		45809		6.01
PROVIDER TO .02				6.02
PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY		223687		7
NAME OF INTERMEDIARY:	_____			
SIGNATURE OF AUTHORIZED PERSON:	_____			
	INTERMEDIARY NUMBER:		_____	
	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		156685			1
2	INPATIENT ROUTINE SERVICES - SWING BED - NF					2
3	ANCILLARY SERVICES		70015			3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					4
5	PROGRAM DAYS		172			5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM					6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY					7
8	SUBTOTAL		226700			8
9	PRIMARY PAYER PAYMENTS					9
10	SUBTOTAL		226700			10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)					11
12	SUBTOTAL		226700			12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		3013			13
14	80% OF PART B COSTS					14
15	SUBTOTAL		223687			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		223687			18
19	SEQUESTRATION ADJUSTMENT					19
20	INTERIM PAYMENTS		177878			20
20.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					20.01
21	BALANCE DUE PROVIDER/PROGRAM		45809			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	3902144				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	3902144				4
5	PRIMARY PAYER PAYMENTS					5
6	TOTAL COST	3941165				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	3941165				19
20	DEDUCTIBLES	433053				20
21	EXCESS REASONABLE COST					21
22	SUBTOTAL	3508112				22
23	COINSURANCE					23
24	SUBTOTAL	3508112				24
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	96984				25
25.01	REDUCED REIMBURSABLE BAD DEBTS	96984				25.01
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	86669				25.02
26	SUBTOTAL	3605096				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	3605096				30
31	SEQUESTRATION ADJUSTMENT					31
32	INTERIM PAYMENTS	3412797				32
32.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)					32.01
33	BALANCE DUE PROVIDER/PROGRAM	192299				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		469310					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		469310					6
7	INPATIENT PRIMARY PAYER PAYMENTS							7
8	OUTPATIENT PRIMARY PAYER PAYMENTS							8
9	SUBTOTAL		469310					9
	COMPUTATION OF LESSER OF COST OR CHARGES							
10	ROUTINE SERVICE CHARGES							10
11	ANCILLARY SERVICE CHARGES		702875					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		469310					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		469310					30
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED							31
32	LESSER OF LINES 30 OR 31		469310					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	469310					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	469310					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	469310					52
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT						53
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						54
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER	469310					55
56	SEQUESTRATION ADJUSTMENT						56
57	INTERIM PAYMENTS						57
57.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						57.01
58	BALANCE DUE PROVIDER/PROGRAM	469310					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	3253914			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	5510975			4
5	OTHER RECEIVABLES	5004			5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2069000			6
7	INVENTORY	376145			7
8	PREPAID EXPENSES	430811			8
9	OTHER CURRENT ASSETS	193028			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS	7700877			11
FIXED ASSETS					
12	LAND	61162			12
12.01	ACCUMULATED DEPRECIATION				12.01
13	LAND IMPROVEMENTS	834285			13
13.01	ACCUMULATED DEPRECIATION	-523762			13.01
14	BUILDINGS	19627361			14
14.01	ACCUMULATED DEPRECIATION	-5532163			14.01
15	LEASEHOLD IMPROVEMENTS				15
15.01	ACCUMULATED AMORTIZATION				15.01
16	FIXED EQUIPMENT	1510248			16
16.01	ACCUMULATED DEPRECIATION	-796296			16.01
17	AUTOMOBILES AND TRUCKS				17
17.01	ACCUMULATED DEPRECIATION				17.01
18	MAJOR MOVABLE EQUIPMENT	8368312			18
18.01	ACCUMULATED DEPRECIATION	-5438830			18.01
19	MINOR EQUIPMENT DEPRECIABLE				19
19.01	ACCUMULATED DEPRECIATION				19.01
20	MINOR EQUIPMENT-NONDEPRECIABLE				20
21	TOTAL FIXED ASSETS	18110317			21
OTHER ASSETS					
22	INVESTMENTS	3770840			22
23	DEPOSITS ON LEASES				23
24	DUE FROM OWNERS/OFFICERS				24
25	OTHER ASSETS	642564			25
26	TOTAL OTHER ASSETS	4413404			26
27	TOTAL ASSETS	30224598			27
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
28	ACCOUNTS PAYABLE	1358692			28
29	SALARIES, WAGES & FEES PAYABLE	978713			29
30	PAYROLL TAXES PAYABLE				30
31	NOTES & LOANS PAYABLE (SHORT TERM)	215000			31
32	DEFERRED INCOME				32
33	ACCELERATED PAYMENTS				33
34	DUE TO OTHER FUNDS				34
35	OTHER CURRENT LIABILITIES	727979			35
36	TOTAL CURRENT LIABILITIES	3280384			36
LONG-TERM LIABILITIES					
37	MORTGAGE PAYABLE	6840000			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	6840000			42
43	TOTAL LIABILITIES	10120384			43
CAPITAL ACCOUNTS					
44	GENERAL FUND BALANCE	20104214			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	20104214			51
52	TOTAL LIABILITIES AND FUND BALANCES	30224598			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	18738005			1
2 NET INCOME (LOSS)	1366209			2
3 TOTAL	20104214			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5				5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS				10
11 SUBTOTAL	20104214			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	20104214			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	2336834		2336834	2
4 SUBPROVIDER I				4
5 SWING BED - SNF	41698		41698	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	2378532		2378532	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	265400		265400	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	265400		265400	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES	2643932		2643932	18
19 ANCILLARY SERVICES	7008616		7008616	19
20 OUTPATIENT SERVICES		36376993	36376993	20
18.50 PHOTOS RHC		939366	939366	18.50
18.60 FQHC				18.60
19 HOME HEALTH AGENCY		28798	28798	19
20 AMBULANCE				20
21 CORF				21
22 ASC				22
23 HOSPICE				23
24				24
25 TOTAL PATIENT REVENUES	9652548	37345157	46997705	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		22342473	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		22342473	40

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES	46997705	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	23885102	2
3	NET PATIENT REVENUES	23112603	3
4	LESS - TOTAL OPERATING EXPENSES	22342473	4
5	NET INCOME FROM SERVICE TO PATIENTS	770130	5
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	29721	6
7	INCOME FROM INVESTMENTS	32639	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	150342	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	25	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	2320	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	PROPERTY TAX REVENUE	344922	24
24.01	OTHER OPERATING INCOME (EXPENSE)	-1691	24.01
24.02	LOSS ON DISPOSITION OF EQUIPMENT	-1968	24.02
24.03	NONCAPITAL GRANTS AND CONTRIBUTIONS	39769	24.03
24.04	TRANSFER OF FOUNDATION ASSETS		24.04
25	TOTAL OTHER INCOME	596079	25
26	TOTAL	1366209	26
27			27
28			28
29			29
30	TOTAL OTHER EXPENSES		30
31	NET INCOME (OR LOSS) FOR THE PERIOD	1366209	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	8528	1239			5527	15294
6 HHA REIMBURSABLE SERVICES						5
6 SKILLED NURSING CARE	8840	1285	1135			11260
7 PHYSICAL THERAPY				1547		1547
8 OCCUPATIONAL THERAPY				91		91
9 SPEECH PATHOLOGY						9
10 MEDICAL SOCIAL SERVICES						10
11 HOME HEALTH AIDE						11
12 SUPPLIES					170	170
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	17368	2524	1135	1638	5697	28362

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	
1					1
2					2
3					3
4					4
5		15294		15294	5
6		11260		11260	6
7		1547		1547	7
8		91		91	8
9					9
10					10
11					11
12		170		170	12
13					13
13.20					13.20
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
23.50					23.50
24		28362		28362	24

COST ALLOCATION - HHA GENERAL SERVICE COST

HHA NO.: 14-7429

WORKSHEET H-4
 PART I

	NET EXPENSES FOR COST ALLOCATION 0	CAP REL BLDGS & FIXTURES 1	CAP REL MOVABLE EQUIPMENT 2	PLANT OPERATN & MAINT 3	TRANSPORT- ATION 4	SUBTOTAL 4A	ADMIN & GENERAL 5	TOTAL 6
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	15294					15294	15294	5
HHA REIMBURSABLE SERVICES								
6 SKILLED NURSING CARE	11260					11260	13177	24437 6
7 PHYSICAL THERAPY	1547					1547	1811	3358 7
8 OCCUPATIONAL THERAPY	91					91	107	198 8
9 SPEECH PATHOLOGY								9
10 MEDICAL SOCIAL SERVICES								10
11 HOME HEALTH AIDE								11
12 SUPPLIES	170					170	199	369 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	28362					28362		28362 24

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					-15294	13068	5
6 SKILLED NURSING CARE						11260	6
7 PHYSICAL THERAPY						1547	7
8 OCCUPATIONAL THERAPY						91	8
9 SPEECH PATHOLOGY							9
10 MEDICAL SOCIAL SERVICES							10
11 HOME HEALTH AIDE							11
12 SUPPLIES						170	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					-15294	13068	24
25 COST TO BE ALLOC (PER W/S H)						15294	25
26 UNIT COST MULTIPLIER						1.170340	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					15706		15706		1
2 SKILLED NURSING CARE					28181		28181	13673	2
3 PHYSICAL THERAPY					3586		3586	1740	3
4 OCCUPATIONAL THERAPY					211		211	102	4
5 SPEECH PATHOLOGY									5
6 MEDICAL SOCIAL SERVICES									6
7 HOME HEALTH AIDE									7
8 SUPPLIES					394		394	191	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					48078		48078	15706	20
21 UNIT COST MULTIPLIER								.485172	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	41854	2
3 PHYSICAL THERAPY	5326	3
4 OCCUPATIONAL THERAPY	313	4
5 SPEECH PATHOLOGY		5
6 MEDICAL SOCIAL SERVICES		6
7 HOME HEALTH AIDE		7
8 SUPPLIES	585	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	48078	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			220	3292	8528		7029	1
2 SKILLED NURSING CARE					8840		26391	2
3 PHYSICAL THERAPY							3358	3
4 OCCUPATIONAL THERAPY							198	4
5 SPEECH PATHOLOGY								5
6 MEDICAL SOCIAL SERVICES								6
7 HOME HEALTH AIDE								7
8 SUPPLIES							369	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			220	3292	17368		37345	20
21 TOTAL COST TO BE ALLOCATED			1853	3291	3839		2533	21
22 UNIT COST MULTIPLIER			8.422727		.221039		.067827	22
22 UNIT COST MULTIPLIER				.999696				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		220		4		64		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		220		4		64		20
21 TOTAL COST TO BE ALLOCATED		4912		1081		2194		21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER		22.327273		270.250000		34.281250		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		94	171					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		94	171					20
21 TOTAL COST TO BE ALLOCATED		13						21
22 UNIT COST MULTIPLIER								22
22 UNIT COST MULTIPLIER		.138298						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	41854		41854	145	288.65	1
2	PHYSICAL THERAPY	3	5326		5326	39	136.56	2
3	OCCUPATIONAL THERAPY	4	313		313	2	156.50	3
4	SPEECH PATHOLOGY	5						4
5	MEDICAL SOCIAL SERV	6						5
6	HOME HEALTH AIDE SERV	7						6
7	TOTAL		47493		47493	186		7
LIMITATION COST COMPUTATION			MSA				PROGRAM	
PATIENT SERVICES			NO.				COST	
			1	2	3	4	LIMITS	
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	RATIO	
OTHER PATIENT SERVICES		WKST H-5, PART I, COL 29, LINE	COSTS	ANCILLARY COSTS	COSTS	CHARGES		
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	585		585			15
16	COST OF DRUGS	9						16
16.20	COST OF ADMINISTERING VACCINES	9.20						16.20
PER BENEFICIARY COST LIMITATION:						MSA	AMOUNT	
						NO.		
						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	24125	2857	10.01
10.02 TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			10.02
10.03 TOTAL PPS REIMBURSEMENT - LUPA EPISODES	179	1688	10.03
10.04 TOTAL PPS REIMBURSEMENT - PEP EPISODES	4086		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	28390	4545	12
13 EXCESS REASONABLE COST			13
14 SUBTOTAL	28390	4545	14
15 COINSURANCE BILLED TO PROGRAM PATIENTS			15
16 NET COST	28390	4545	16
17 REIMBURSABLE BAD DEBTS			17
17.01 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES			17.01
18 TOTAL COSTS - CURRENT COST REPORTING PERIOD	28390	4545	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	28390	4545	22
23 SEQUESTRATION ADJUSTMENT			23
24 SUBTOTAL	28390	4545	24
25 TOTAL INTERIM PAYMENTS	28390	4545	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		28390		4545	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.	PROGRAM .01 TO .02 PROVIDER .03 PROVIDER .04 TO .05 PROVIDER .50 TO .51 PROGRAM .53 .54				3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54
SUBTOTAL	.99				3.99
4 TOTAL INTERIM PAYMENTS		28390		4545	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				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 PROVIDER .01 PROVIDER TO .02 PROGRAM				6.01 6.02
7 TOTAL MEDICARE PROGRAM LIABILITY		28390		4545	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					22
23 I&R SERVICES-OTHER PRGM COSTS					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 C					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
53 ELECTROCARDIOLOGY					53
55 MEDICAL SUPPLIES CHARGED TO PA					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
60 CLINIC					60
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 THERAP					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 & CA					96
98 PHYSICIANS' PRIVATE OFFICES					98
98.01 TEMPORALLY IDLE SPACE					98.01
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

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	87170	6563	93733		93733		2
3 NURSE PRACTITIONER							3
4 VISITING NURSE							4
5 OTHER NURSE	116298	8756	125054		125054		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)	203468	15319	218787		218787		10
COSTS UNDER AGREEMENT							
11 PHYSICIAN SERVICES UNDER AGREEMENT		295747	295747		295747		11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT							12
13 OTHER COSTS UNDER AGREEMENT							13
14 SUBTOTAL (SUM OF LINES 11-13)		295747	295747		295747		14
OTHER HEALTH CARE COSTS							
15 MEDICAL SUPPLIES		8280	8280		8280		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)		8280	8280		8280		21
22 TOTAL COSTS OF HEALTH CARE SERVICES COSTS OTHER THAN RHC/FQHC SERVICES	203468	319346	522814		522814		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							28
FACILITY OVERHEAD							
29 FACILITY COSTS							29
30 ADMINISTRATIVE COSTS	36239	3277	39516		39516		30
31 TOTAL FACILITY OVERHEAD	36239	3277	39516		39516		31
32 TOTAL FACILITY COSTS	239707	322623	562330		562330		32

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	1.09	2297	2100	2289		2
3 NURSE PRACTITIONERS			2100			3
4 SUBTOTAL	1.09	2297		2289	2297	4
5 VISITING NURSE						5
6 CLINICAL PSYCHOLOGIST						6
7 CLINICAL SOCIAL WORKER						7
8 TOTAL FTEs AND VISITS	1.09	2297			2297	8
9 PHYSICIAN SERVICES UNDER AGREEMENTS		1460			1460	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10 TOTAL COSTS OF HEALTH CARE SERVICES					522814	10
11 TOTAL NONREIMBURSABLE COSTS						11
12 COST OF ALL SERVICES (EXCLUDING OVERHEAD)					522814	12
13 RATIO OF RHC/FQHC SERVICES					1.000000	13
14 TOTAL FACILITY OVERHEAD					39516	14
15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY					181187	15
16 TOTAL OVERHEAD					220703	16
17 ALLOWABLE GME OVERHEAD						17
18 SUBTRACT LINE 17 FROM LINE 16					220703	18
19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES					220703	19
20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES					743517	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	743517	1
2	COST OF VACCINES AND THEIR ADMINISTRATION	17328	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE	726189	3
4	TOTAL VISITS	2297	4
5	PHYSICIANS VISITS UNDER AGREEMENT	1460	5
6	TOTAL ADJUSTED VISITS	3757	6
7	ADJUSTED COST PER VISIT	193.29	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	193.29	193.29	9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES	303	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES	58567	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	58567	16
16.01	PRIMARY PAYOR PAYMENTS		16.01
17	LESS: BENEFICIARY DEDUCTIBLE	6024	17
18	NET PROGRAM COST EXCLUDING VACCINES	52543	18
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE	42034	19
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION	17329	20
21	TOTAL REIMBURSABLE PROGRAM COST	59363	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	59363	24
25	INTERIM PAYMENTS	102377	25
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		25.01
26	BALANCE DUE COMPONENT/PROGRAM	-43014	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.

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	SEASONAL INFLUENZA 2	H1N1 VACCINE (SERVICES ON/AFTER 10/1/2009) 2.01	COMBINATION INFLUENZA & H1N1 IN SAME VISIT 2.02	
1 HEALTH CARE STAFF COSTS	218787	218787	218787	218787	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.016250	0.016250			2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST	3555	3555			3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE	237	4837			4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE	3792	8392			5
6 TOTAL DIRECT COST OF THE FACILITY	522814	522814	522814	522814	6
7 TOTAL OVERHEAD	220703	220703	220703	220703	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIECT COST	0.007253	0.016052			8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE	1601	3543			9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION	5393	11935			10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS	6	435			11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION	898.83	27.44			12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES	6	435			13
14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION	5393	11936			14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		17328			15
16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION		17329			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		32212	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 10/16/2009	4743	3.01
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM .02 09/18/2009	65422	3.02
REVISION OF THE INTERIM RATE FOR THE COST	TO .03		3.03
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER .04		3.04
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.05		3.05
	PROVIDER .50		3.50
	PROVIDER .51		3.51
	TO .52	NONE	3.52
	PROGRAM .53		3.53
	.54		3.54
SUBTOTAL	.99	70165	3.99
4 TOTAL INTERIM PAYMENTS		102377	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 PROVIDER .01		6.01
	PROVIDER TO .02	-43014	6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY		59363	7
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	67.92		5.58				73.50 25
UTILIZATION PERCENTAGES BASED ON CHARGES							
37 OPERATING ROOM	9.38	43.58	3.87				56.83 37
41 RADIOLOGY-DIAGNOSTIC	6.41	36.05	1.16				43.62 41
44 LABORATORY	11.49	33.04	1.46				45.99 44
49 RESPIRATORY THERAPY	12.51	19.95	1.91				34.37 49
50 PHYSICAL THERAPY	5.45	34.08	0.35				39.88 50
53 ELECTROCARDIOLOGY	8.23	58.74					66.97 53
55 MEDICAL SUPPLIES CHARGED TO PAT	44.61	37.34	3.58				85.53 55
56 DRUGS CHARGED TO PATIENTS	33.94	30.49	3.77				68.20 56
60 CLINIC	0.03	51.03					51.06 60
61 EMERGENCY	0.07	35.44	1.69				37.20 61
62 OBSERVATION BEDS (NON-DISTINCT	0.43	55.13					55.56 62
101 TOTAL CHARGES	10.42	32.45	1.59				44.46 101

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
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	641853	3.39	-641853	-7.15			3
4 NEW CAP REL COSTS-MVBLE EQUIP	1510583	7.98	-1510583	-16.82			4
5 EMPLOYEE BENEFITS	1591639	8.41	-1591639	-17.72			5
6.01 ADMINISTRATIVE & ACCOUNTING	967380	5.11	-967380	-10.77			6.01
6.02 BUSINESS SERVICES	908148	4.80	-908148	-10.11			6.02
7 MAINTENANCE & REPAIRS							7
8 OPERATION OF PLANT	879109	4.65	-879109	-9.79			8
9 LAUNDRY & LINEN SERVICE	57944	.31	-57944	-.65			9
10 HOUSEKEEPING	230645	1.22	-230645	-2.57			10
11 DIETARY	118154	.62	-118154	-1.32			11
12 CAFETERIA	351742	1.86	-351742	-3.92			12
13 MAINTENANCE OF PERSONNEL							13
14 NURSING ADMINISTRATION	135519	.72	-135519	-1.51			14
15 CENTRAL SERVICES & SUPPLY							15
15.01 PURCHASING	94395	.50	-94395	-1.05			15.01
15.02 CENTRAL SERVICES & SUPPLY							15.02
16 PHARMACY	1054117	5.57	-1054117	-11.74			16
17 MEDICAL RECORDS & LIBRARY	392078	2.07	-392078	-4.37			17
18 SOCIAL SERVICE	47867	.25	-47867	-.53			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	1812158	9.58	1784879	19.87	3597037	19.01	25
26 INTENSIVE CARE UNIT							26
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM	856682	4.53	977110	10.88	1833792	9.69	37
40 ANESTHESIOLOGY							40
41 RADIOLOGY-DIAGNOSTIC	1280695	6.77	1822336	20.29	3103031	16.40	41
44 LABORATORY	1516330	8.01	976300	10.87	2492630	13.17	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49 RESPIRATORY THERAPY	426746	2.26	309054	3.44	735800	3.89	49
50 PHYSICAL THERAPY	812905	4.30	270314	3.01	1083219	5.72	50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53 ELECTROCARDIOLOGY	63602	.34	59084	.66	122686	.65	53
55 MEDICAL SUPPLIES CHARGED TO PAT	537591	2.84	132443	1.47	670034	3.54	55
56 DRUGS CHARGED TO PATIENTS	36699	.19	1273475	14.18	1310174	6.92	56
60 CLINIC	135586	.72	78391	.87	213977	1.13	60
60.01 SALEM MEDICAL CLINIC							60.01
61 EMERGENCY	1802245	9.52	738275	8.22	2540520	13.42	61
62 OBSERVATION BEDS (NON-DISTINCT							62

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
63.50 PHOTOS RHC	562330	2.97	181187	2.02	743517	3.93	63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE 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	28362	.15	19716	.22	48078	.25	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	25847	.14	17425	.19	43272	.23	96
98 PHYSICIANS' PRIVATE OFFICES	45291	.24	129330	1.44	174621	.92	98
98.01 TEMPORARILY IDLE SPACE			211854	2.36	211854	1.12	98.01
101 CROSS FOOT ADJUSTMENTS							101
102 NEGATIVE COST CENTER							102
103 TOTAL	18924242	100.00	0	.00	18924242	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 OPSS. (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)	4782027
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPSS. (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)	13609750
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)	.351