

SALEM TOWNSHIP HOSPITAL
SALEM, ILLINOIS
MEDICARE ANALYSIS
FOR THE YEAR ENDED MARCH 31, 2011

National Government Services, Inc.
Cost Reporting Unit
PO Box 7149
Indianapolis, IN 46207-7149

Dear Sir or Madam:

This cost report of Salem Township Hospital for the fiscal year ended March 31, 2011 includes one Level 2000 Errors.

2027 Worksheet C, Part I, Line 63.50, Col 11 should not be more than 100% or less than 1%.

The Hospital's rural health clinic cost to charge ratio was 2.540161 as the number of visits in 2011 did not generate enough revenue to cover the expense of the clinic including allocated overhead. As a rural hospital Salem Township Hospital qualifies for cost reimbursement for these services. The reimbursement program is designed for rural hospitals with lower clinic volumes which operate in rural underserved areas.

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: 08/02/2011
 APPLICABLE BOX _____ MANUALLY SUBMITTED COST REPORT TIME: 08:24

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 04/01/2010 AND ENDING 03/31/2011, 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: 08/02/2011 08:24
 Aq2NT88i0iCSktujeI+IBLOIyToNu0
 NGz0t0zKpAX8LmPyfIeTcqIdalgcmL
 bj6p0MGRc80Drfzp

(SIGNED) _____
 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

PI Encryption: 08/02/2011 08:24
 sbFN3F9LKOVb1nU3NdOkMUhv.JEPY0
 ZjAjE0q6x8iamCULXXNda7qj8d3bZL
 SCAE7P7Fyi0HBZJh

 DATE

PART II - SETTLEMENT SUMMARY

| | TITLE V | TITLE XVIII | | TITLE XIX | |
|-----|------------------------------------|-------------|--------|-----------|-----|
| | | PART A | PART B | | |
| 1 | HOSPITAL | 405167 | 196742 | 495621 | 1 |
| 2 | SUBPROVIDER I | | | | 2 |
| 3 | SWING BED - SNF | 15713 | | | 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 | | 27935 | | 9 |
| 100 | TOTAL | 420880 | 224677 | 495621 | 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 1.01

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 XVIII XIX | | | | |
|----------------|------------------------------------|----------------------------|------------------------|---|---|---|---|----|
| | | | | 4 | 5 | 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-Z345 | 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: 04/01/2010 | TO: 03/31/2011 | | | | 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. | | | | | 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. | | | | 2 | | Y | 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. | | | | 2 | | | 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. | | | | 2 | | | 21.05 |
| 21.06 | DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION (OR APPLICABLE EXTENSION) OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105, MIPPA 147, ACA 3121, OR MMEA 108? (SEE INSTRUCTIONS). ENTER 'Y' FOR YES OR 'N' FOR NO. | | | | NO | | | 21.06 |
| 21.07 | DOES THIS HOSPITAL QUALIFY AS AN SCH WITH 100 OR FEWER BEDS UNDER MIPPA 147? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). IS THIS AN SCH OR BACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121 OR MMEA SECTION 108? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO (SEE INSTRUCTIONS). | | | | NO | NO | | 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. | | | | | | NO | 21.08 |
| 22 | ARE YOU CLASSIFIED AS A REFERRAL CENTER? | | | | NO | | | 22 |
| 23 | DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW | | | | NO | | | 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 |
| 25.07 | HAS YOUR FACILITY'S TRAINED RESIDENTS IN NON-PROVIDER SETTING DURING THE COST REPORTING PERIOD? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. | NO | | | 25.07 |
| 25.08 | IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE WEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. IF LINE 25.07 IS YES, ENTER IN COLUMN 1 THE UNWEIGHTED NUMBER OF NON-PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. USE LINES 25.09 THROUGH 25.59 AS NECESSARY TO IDENTIFY THE PROGRAM NAME IN COLUMN 1, THE PROGRAM CODE IN COLUMN 2, AND THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS BY SPECIALTY IN COLUMN 3 FOR EACH PRIMARY CARE SPECIALTY PROGRAM IN WHICH RESIDENTS ARE TRAINED. | 0.00 | | | 25.08 |
| | | | PROGRAM CODE(2) | RESIDENT FTEs(3) | |
| 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 |

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

OTHER INFORMATION

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 |
| 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 | | | | | |
| | | | V | XVIII | XIX |
| 36 | DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? | | 1 | 2 | 3 |
| 36.01 | DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320? | | NO | NO | NO |
| 37 | DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? | | NO | NO | NO |
| 37.01 | IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE? | | | | |
| 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 |

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

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 NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE. 46

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

| | PART A | PART B | OUTPATIENT ASC | OUTPATIENT RADIOLOGY | OUTPATIENT DIAGNOSTIC | |
|-----------------------------|--------|--------|----------------|----------------------|-----------------------|----|
| | 1 | 2 | 3 | 4 | 5 | |
| 47 HOSPITAL | Y | Y | N | N | N | 47 |
| 48 SUBPROVIDER I | N | N | N | N | N | 48 |
| 49 SKILLED NURSING FACILITY | N | N | 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

56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002. DATE Y/N LIMIT Y/N FEES
 0 1 2 3 4
 / / 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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 (CONTINUED)

| | | | | | | |
|--------------------|--|-------------|---------------|-----------|---------------------|-------|
| 60 | ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? 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: 1 | STATE: 2 | ZIP CODE 3 | CBSA 4 | FTE/ CAMPUS 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 |
| MISCELLANEOUS DATA | | | | | | |
| 64 | DOES THIS HOSPITAL HAVE DIRECT ASSIGNMENT OF COST FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. | NO | | | | 64 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

| COMPONENT | NO. OF BEDS 1 | BED DAYS AVAILABLE 2 | CAH PATIENT HOURS 2.01 | -----I/P DAYS / O/P VISITS / TRIPS----- | | | OBS. BEDS ADMITTED 5.01 | |
|--|---------------------|----------------------------|---------------------------------|---|---------------------|-------------------------------------|----------------------------------|-------------------|
| | | | | TITLE V 3 | TITLE XVIII 4 | TITLE NONCOVERED DAYS 4.01 | | TITLE XIX 5 |
| 1 HOSPITAL ADULTS & PEDS, EXCL SWING BED, OBSERV & HOSPICE DAYS | 25 | 9125 | 87600.00 | | 2835 | | 246 | 1 |
| 2 HMO | | | | | | | | 2 |
| 3 HOSPITAL ADULTS & PEDS - SWING BED SNF | | | | | 107 | | | 3 |
| 4 HOSPITAL ADULTS & PEDS - SWING BED NF | | | | | | | | 4 |
| 5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS | 25 | 9125 | 87600.00 | | 2942 | | 246 | 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 | 25 | 9125 | 87600.00 | | 2942 | | 246 | 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 | | | | | 368 | | | 24 |
| 25 TOTAL | 25 | | | | | | | 25 |
| 26 OBSERVATION BED DAYS | | | | | | | | 26 |
| 27 AMBULANCE TRIPS | | | | | | | | 27 |
| 28 EMPLOYEE DISCOUNT DAYS | | | | | | | | 28 |
| 29 LABOR & DELIVERY DAYS | | | | | | | | 29 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

| COMPONENT | -----I/P DAYS / O/P VISITS / TRIPS----- | | | | ---INTERNS & RES FTES---- | | | --FULL TIME EQUIV-- | |
|---|---|-----------------------|--------------------------|------------------------------|---------------------------|------------------------------------|-----|-------------------------|--------------------|
| | OBS. BEDS NOT ADMITTED | TOTAL ALL PATIENTS | OBS. BEDS ADMITTED | OBS. BEDS NOT ADMITTED | TOTAL | LESS I&R REPL NON- PHYS ANES | NET | EMPLOYEES ON PAYROLL | NONPAID WORKERS |
| | 5.02 | 6 | 6.01 | 6.02 | 7 | 8 | 9 | 10 | 11 |
| 1 HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS | | 3650 | | | | | | | 1 |
| 2 HMO XIX | | | | | | | | | 2 |
| 3 HOSPITAL ADULTS & PEDS - SWING BED SNF | | 107 | | | | | | | 3 |
| 4 HOSPITAL ADULTS & PEDS - SWING BED NF | | | | | | | | | 4 |
| 5 TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS | | 3757 | | | | | | | 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 | | 3757 | | | | | | 172.59 | 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 | | 3248 | | | | | | 5.73 | 24 |
| 25 TOTAL | | | | | | | | 178.32 | 25 |
| 26 OBSERVATION BED DAYS | | 172 | | | | | | | 26 |
| 27 AMBULANCE TRIPS | | | | | | | | | 27 |
| 28 EMPLOYEE DISCOUNT DAYS | | | | | | | | | 28 |
| 29 LABOR & DELIVERY DAYS | | | | | | | | | 29 |

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

| | | -----DISCHARGES----- | | | | |
|-----------|---|----------------------|--------------------|-----------------------------|------|----|
| COMPONENT | TITLE V 12 | TITLE XVIII 13 | TITLE XIX 14 | TOTAL ALL PATIENTS 15 | | |
| 1 | HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS | | 742 | 86 | 1030 | 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 | | 742 | 86 | 1030 | 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 | RECLASS. | ADJUSTED | PAID HOURS | AVERAGE | DATA | WORKSHEET S-3 |
|---------------------|---|----------|-------------|----------|------------|-------------|---------|---------------|
| | | REPORTED | OF SALARIES | SALARIES | RELATED | HOURLY WAGE | SOURCE | PART II |
| | | 1 | FROM WKST. | (COL.1 + | TO SALARY | (COL.3 / | | |
| | | | A-6 | COL.2) | IN COL.3 | COL.4) | | |
| | | | 2 | 3 | 4 | 5 | 6 | |
| 1 | SALARIES | | | | | | | 1 |
| 2 | TOTAL SALARIES | 7217882 | | | | | | 2 |
| 3 | NON-PHYSICIAN ANESTHETIST PART A | | | | | | | 3 |
| 4 | NON-PHYSICIAN ANESTHETIST PART B | | | | | | | 4 |
| 4.01 | PHYSICIAN - PART A | | | | | | | 4 |
| 5 | TEACHING PHYSICIAN SALARIES | | | | | | | 4.01 |
| 5.01 | PHYSICIAN - PART B | | | | | | | 5 |
| 6 | NON-PHYSICIAN - PART B | | | | | | | 5.01 |
| 6.01 | INTERNS & RESIDENTS (IN APPR PGM) | | | | | | | 6 |
| 7 | CONTRACT SERVICES, I&R | | | | | | | 6.01 |
| 8 | HOME OFFICE PERSONNEL | | | | | | | 7 |
| 8.01 | SNF | | | | | | | 8 |
| 9 | EXCLUDED AREA SALARIES | 83283 | | | | | | 8.01 |
| 9.01 | OTHER WAGES & RELATED COSTS | | | | | | | 9 |
| 9.02 | CONTRACT LABOR | | | | | | | 9.01 |
| 9.03 | PHARMACY SERVICES UNDER CONTRACT | | | | | | CMS 339 | 9.02 |
| 10 | LABORATORY SERVICES UNDER CONTRACT | | | | | | CMS 339 | 9.03 |
| 10.01 | MANAGEMENT AND ADMINISTRATIVE SERVICES' | | | | | | CMS 339 | 10 |
| 11 | CONTRACT LABOR: PHYSICIAN PART A | | | | | | CMS 339 | 10.01 |
| 12 | TEACHING PHYSICIAN UNDER CONTRACT | | | | | | CMS 339 | 11 |
| 12.01 | HOME OFFICE SALARIES & WAGE REL COSTS | | | | | | CMS 339 | 12 |
| 13 | HOME OFFICE: PHYSICIAN PART A | | | | | | CMS 339 | 12.01 |
| 14 | TEACHING PHYSICIAN SALARIES | | | | | | CMS 339 | 13 |
| 15 | WAGE-RELATED COSTS | | | | | | CMS 339 | 14 |
| 16 | WAGE RELATED COSTS (CORE) | | | | | | CMS 339 | 15 |
| 17 | WAGE RELATED COSTS (OTHER) | | | | | | CMS 339 | 16 |
| 18 | EXCLUDED AREAS | | | | | | CMS 339 | 17 |
| 18.01 | NON-PHYSICIAN ANESTHETIST PART A | | | | | | CMS 339 | 18 |
| 19 | NON-PHYSICIAN ANESTHETIST PART B | | | | | | CMS 339 | 18.01 |
| 19.01 | PHYSICIAN PART A | | | | | | CMS 339 | 19 |
| 20 | PART A TEACHING PHYSICIANS | | | | | | CMS 339 | 19.01 |
| 21 | PHYSICIAN PART B | | | | | | CMS 339 | 20 |
| 22 | WAGE RELATED COSTS (RHC/FQHC) | | | | | | CMS 339 | 21 |
| 23 | INTERNS & RESIDENTS (IN APPR PGM) | | | | | | CMS 339 | 22 |
| 24 | OVERHEAD COSTS - DIRECT SALARIES | | | | | | | 23 |
| 25 | EMPLOYEE BENEFITS | 101181 | | | | | | 24 |
| 26 | ADMINISTRATIVE & GENERAL | 1064659 | | | | | | 25 |
| 26.01 | ADMINISTRATIVE & GENERAL UNDER CONTACT | | | | | | | 26 |
| 27 | MAINTENANCE & REPAIRS | | | | | | | 26.01 |
| 28 | OPERATION OF PLANT | 295301 | | | | | | 27 |
| 29 | LAUNDRY & LINEN SERVICE | 35308 | | | | | | 27.01 |
| 30 | HOUSEKEEPING | 141179 | | | | | | 28 |
| 31 | HOUSEKEEPING UNDER CONTRACT | | | | | | | 29 |
| 32 | DIETARY | 240282 | -179539 | | | | | 30 |
| 33 | DIETARY UNDER CONTRACT | | | | | | | 31 |
| 34 | CAFETERIA | | 179539 | | | | | 32 |
| 35 | MAINTENANCE OF PERSONNEL | | | | | | | 33 |
| 36 | NURSING ADMINISTRATION | 53406 | | | | | | 34 |
| 37 | CENTRAL SERVICES AND SUPPLY | 95235 | -13877 | | | | | 35 |
| 38 | PHARMACY | 49107 | | | | | | |
| 39 | MEDICAL RECORDS & MEDICAL RECORDS LIBR | 213065 | | | | | | |
| 40 | SOCIAL SERVICE | 43219 | | | | | | |
| 41 | OTHER GENERAL SERVICE | | | | | | | |

HOSPITAL WAGE INDEX INFORMATION

| PART III - HOSPITAL WAGE INDEX SUMMARY | | AMOUNT | RECLASS. | ADJUSTED | PAID HOURS | AVERAGE | DATA | WORKSHEET S-3 |
|--|---|----------|-------------|----------|------------|-------------|--------|---------------|
| | | REPORTED | OF SALARIES | SALARIES | RELATED | HOURLY WAGE | SOURCE | PART III |
| | | 1 | FROM WKST. | (COL.1 + | TO SALARY | (COL.3 / | | |
| | | | A-6 | COL.2) | IN COL.3 | COL.4) | | |
| | | | 2 | 3 | 4 | 5 | | |
| 1 | NET SALARIES | 7217882 | | 7217882 | | | | 1 |
| 2 | EXCLUDED AREA SALARIES | 83283 | | 83283 | | | | 2 |
| 3 | SUBTOTAL SALARIES (LINE 1 MINUS LINE 2) | 7134599 | | 7134599 | | | | 3 |
| 4 | SUBTOTAL OTHER WAGES & REL COSTS | | | | | | | 4 |
| 5 | SUBTOTAL WAGE-RELATED COSTS | | | | | | | 5 |
| 6 | TOTAL (SUM OF LINES 3 THRU 5) | 7134599 | | 7134599 | | | | 6 |
| 7 | NET SALARIES | | | | | | | 7 |
| 8 | EXCLUDED AREA SALARIES | | | | | | | 8 |
| 9 | SUBTOTAL SALARIES (LINE 7 MINUS LINE 8) | | | | | | | 9 |
| 10 | SUBTOTAL OTHER WAGES & REL COSTS | | | | | | | 10 |
| 11 | SUBTOTAL WAGE-RELATED COSTS | | | | | | | 11 |
| 12 | TOTAL (SUM OF LINES 9 THRU 11) | | | | | | | 12 |
| 13 | TOTAL OVERHEAD COSTS | 2331942 | -13877 | 2318065 | | | | 13 |

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:

9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT
 PHYSICIAN NAME BILLING NO. 9

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

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

(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.

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 | | | | | | | | 1 |
| 2 | 0200 | | | | | | | | 2 |
| 3 | 0300 | | 864232 | 864232 | 177903 | 1042135 | | 1042135 | 3 |
| 4 | 0400 | | 759656 | 759656 | 677102 | 1436758 | -500 | 1436258 | 4 |
| 5 | 0500 | 101181 | 1582212 | 1683393 | | 1683393 | -66957 | 1616436 | 5 |
| 6.01 | 0662 | 476519 | 3071656 | 3548175 | -192646 | 3355529 | -2085782 | 1269747 | 6.01 |
| 6.02 | 0661 | 588140 | 417258 | 1005398 | | 1005398 | -27347 | 978051 | 6.02 |
| 7 | 0700 | | | | | | | | 7 |
| 8 | 0800 | 295301 | 691505 | 986806 | -16687 | 970119 | -1842 | 968277 | 8 |
| 9 | 0900 | 35308 | 20467 | 55775 | | 55775 | | 55775 | 9 |
| 10 | 1000 | 141179 | 82413 | 223592 | | 223592 | | 223592 | 10 |
| 11 | 1100 | 240282 | 379061 | 619343 | -463666 | 155677 | -27105 | 128572 | 11 |
| 12 | 1200 | | | | 462773 | 462773 | -110419 | 352354 | 12 |
| 13 | 1300 | | | | | | | | 13 |
| 14 | 1400 | 53406 | 16192 | 69598 | | 69598 | | 69598 | 14 |
| 15 | 1500 | | | | | | | | 15 |
| 15.01 | 1501 | 81358 | 9067 | 90425 | | 90425 | | 90425 | 15.01 |
| 15.02 | 1502 | 13877 | 594434 | 608311 | -608311 | | | | 15.02 |
| 16 | 1600 | 49107 | 1074279 | 1123386 | | 1123386 | -1987 | 1121399 | 16 |
| 17 | 1700 | 213065 | 187345 | 400410 | -1841 | 398569 | -2 | 398567 | 17 |
| 18 | 1800 | 43219 | 8495 | 51714 | | 51714 | | 51714 | 18 |
| 20 | 2000 | | | | 435790 | 435790 | -435790 | | 20 |
| 21 | 2100 | | | | | | | | 21 |
| 22 | 2200 | | | | | | | | 22 |
| 23 | 2300 | | | | | | | | 23 |
| 24 | 2400 | | | | | | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | | | | |
| 25 | 2500 | 1544966 | 231126 | 1776092 | -8994 | 1767098 | | 1767098 | 25 |
| 26 | 2600 | | | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 37 | 3700 | 595441 | 348740 | 944181 | -47367 | 896814 | -24000 | 872814 | 37 |
| 40 | 4000 | 192505 | 300539 | 493044 | -493044 | | | | 40 |
| 41 | 4100 | 426014 | 1388555 | 1814569 | -503484 | 1311085 | | 1311085 | 41 |
| 44 | 4400 | 551139 | 949538 | 1500677 | -890 | 1499787 | | 1499787 | 44 |
| 46.30 | 4650 | | | | | | | | 46.30 |
| 49 | 4900 | 280769 | 244708 | 525477 | -13692 | 511785 | -70656 | 441129 | 49 |
| 50 | 5000 | | 826627 | 826627 | -910 | 825717 | -408 | 825309 | 50 |
| 51 | 5100 | | | | | | | | 51 |
| 52 | 5200 | | | | | | | | 52 |
| 53 | 5300 | 56283 | 56385 | 112668 | | 112668 | -49715 | 62953 | 53 |
| 55 | 5500 | | | | 608311 | 608311 | | 608311 | 55 |
| 56 | 5600 | | | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 60 | 6000 | 127695 | 21688 | 149383 | -96 | 149287 | | 149287 | 60 |
| 60.01 | 6001 | | | | | | | | 60.01 |
| 61 | 6100 | 764608 | 2027270 | 2791878 | -380303 | 2411575 | -738079 | 1673496 | 61 |
| 62 | 6200 | | | | | | | | 62 |
| 63.50 | 6310 | 263237 | 25208 | 288445 | 370052 | 658497 | | 658497 | 63.50 |
| 63.60 | 6320 | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 | 6910 | | | | | | | | 69.10 |
| 69.20 | 6920 | | | | | | | | 69.20 |
| 69.30 | 6930 | | | | | | | | 69.30 |
| 69.40 | 6940 | | | | | | | | 69.40 |
| 71 | 7100 | | | | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 | 8510 | | | | | | | | 85.01 |
| 85.02 | 8520 | | | | | | | | 85.02 |
| 85.03 | 8530 | | | | | | | | 85.03 |
| 95 | | 7134599 | 16178656 | 23313255 | | 23313255 | -3640589 | 19672666 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 | 9600 | 47615 | 52209 | 99824 | | 99824 | | 99824 | 96 |
| 98 | 9800 | 35668 | 3310 | 38978 | | 38978 | | 38978 | 98 |
| 98.01 | 9801 | | | | | | | | 98.01 |
| 101 | TOTAL | 7217882 | 16234175 | 23452057 | | 23452057 | -3640589 | 19811468 | 101 |

RECLASSIFICATIONS

| EXPLANATION OF RECLASSIFICATION ENTRY | CODE | INCREASE | | | | |
|---|------|-------------------------------|--------|--------|---------|----|
| | | COST CENTER | LINE # | SALARY | OTHER | |
| 1 | | 2 | 3 | 4 | 5 | |
| 1 TO RECLASS CAFETERIA COST | A | CAFETERIA | 12 | 179539 | 283234 | 1 |
| 2 TO RECLASS SUPPLY COST | B | MEDICAL SUPPLIES CHARGED TO P | 55 | 13877 | 594434 | 2 |
| 3 TO RECLASS RENTALS | C | NEW CAP REL COSTS-MVBLE EQUIP | 4 | | 677102 | 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 | | 435790 | 17 |
| 18 TO RECLASS REMAINING ANESTHESIA SUPP | E | OPERATING ROOM | 37 | | 57254 | 18 |
| 19 TO RECLASS PHYSICIAN PORTION FOR RHC | G | PHOTOS RHC | 63.50 | | 335972 | 19 |
| 20 TO RECLASS OTHER CAPITAL COSTS | H | NEW CAP REL COSTS-BLDG & FIXT | 3 | | 64997 | 20 |
| 21 TO RECLASS RESP DRUGS CHGD TO PT | I | | | | | 21 |
| 22 TO RECLASS ADMIN EXPENSES FOR RHC | J | PHOTOS RHC | 63.50 | | 34080 | 22 |
| 23 TO RECLASS INTEREST EXPENSE | K | NEW CAP REL COSTS-BLDG & FIXT | 3 | | 112906 | 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 | | | | 193416 | 2595769 | 36 |

RECLASSIFICATIONS

WORKSHEET A-6
 PAGE 1

| EXPLANATION OF RECLASSIFICATION ENTRY | CODE | COST CENTER | DECREASE | | | WKST A-7 REF. 10 |
|--|------|-----------------------------|----------|--------|---------|------------------|
| | | | LINE # | SALARY | OTHER | |
| 1 | 1 | 6 | 7 | 8 | 9 | |
| 1 TO RECLASS CAFETERIA COST | A | DIETARY | 11 | 179539 | 283234 | 1 |
| 2 TO RECLASS SUPPLY COST | B | CENTRAL SERVICES & SUPPLY | 15.02 | 13877 | 594434 | 2 |
| 3 TO RECLASS RENTALS | C | ADULTS & PEDIATRICS | 25 | | 8994 | 10 3 |
| 4 | C | OPERATING ROOM | 37 | | 104621 | 4 |
| 5 | C | DIETARY | 11 | | 893 | 5 |
| 6 | C | LABORATORY | 44 | | 890 | 6 |
| 7 | C | RADIOLOGY-DIAGNOSTIC | 41 | | 503484 | 7 |
| 8 | C | RESPIRATORY THERAPY | 49 | | 13692 | 8 |
| 9 | C | PHYSICAL THERAPY | 50 | | 910 | 9 |
| 10 | C | OPERATION OF PLANT | 8 | | 16687 | 10 |
| 11 | C | ADMINISTRATIVE & ACCOUNTING | 6.01 | | 14743 | 11 |
| 12 | C | MEDICAL RECORDS & LIBRARY | 17 | | 1841 | 12 |
| 13 | C | CLINIC | 60 | | 96 | 13 |
| 14 | C | EMERGENCY | 61 | | 10251 | 14 |
| 15 | C | | | | | 15 |
| 16 | C | | | | | 16 |
| 17 TO RECLASS CRNA COST | D | ANESTHESIOLOGY | 40 | | 435790 | 17 |
| 18 TO RECLASS REMAINING ANESTHESIA S E | E | ANESTHESIOLOGY | 40 | | 57254 | 18 |
| 19 TO RECLASS PHYSICIAN PORTION FOR | G | EMERGENCY | 61 | | 335972 | 19 |
| 20 TO RECLASS OTHER CAPITAL COSTS | H | ADMINISTRATIVE & ACCOUNTING | 6.01 | | 64997 | 14 20 |
| 21 TO RECLASS RESP DRUGS CHGD TO PT | I | | | | | 21 |
| 22 TO RECLASS ADMIN EXPENSES FOR RHC | J | EMERGENCY | 61 | | 34080 | 22 |
| 23 TO RECLASS INTEREST EXPENSE | K | ADMINISTRATIVE & ACCOUNTING | 6.01 | | 112906 | 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 | | | | 193416 | 2595769 | 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 | 834287 | 97827 | | 97827 | | 932114 | | 2 |
| 3 BUILDINGS AND FIXTURES | 19627359 | 12777897 | | 12777897 | 10968884 | 21436372 | | 3 |
| 4 BUILDING IMPROVEMENTS | | | | | | | | 4 |
| 5 FIXED EQUIPMENT | 1510249 | 64177 | | 64177 | 13672 | 1560754 | | 5 |
| 6 MOVABLE EQUIPMENT | 8368314 | 916134 | | 916134 | 359075 | 8925373 | | 6 |
| 7 SUBTOTAL | 30401371 | 13856035 | | 13856035 | 11341631 | 32915775 | | 7 |
| 8 RECONCILING ITEMS | | | | | | | | 8 |
| 9 TOTAL | 30401371 | 13856035 | | 13856035 | 11341631 | 32915775 | | 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 | 8 |
| 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 TCTAL | | | | .000000 | | | | 5 |

| DESCRIPTION | SUMMARY OF OLD AND NEW CAPITAL | | | | | | TOTAL |
|---------------------------------|--------------------------------|--------|----------|-----------|-------|-----------------------------|-----------|
| | DEPRECIATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CAPITAL-RELATED COSTS | |
| | 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 | 864232 | | | | | 177903 | 1042135 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | 759656 | 677102 | | | | -500 | 1436258 4 |
| 5 TOTAL | 1623888 | 677102 | | | | 177403 | 2478393 5 |

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

| DESCRIPTION | SUMMARY OF OLD AND NEW CAPITAL | | | | | | TOTAL |
|---------------------------------|--------------------------------|-------|----------|-----------|-------|-----------------------------|-----------|
| | DEPRECIATION | LEASE | INTEREST | INSURANCE | TAXES | OTHER CAPITAL-RELATED COSTS | |
| | 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 | 864232 | | | | | | 864232 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | 759656 | | | | | | 759656 4 |
| 5 TOTAL | 1623888 | | | | | | 1623888 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 | -25186 | 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 | -1833 | 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 | -882450 | | | 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 | -110419 | 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 | -1987 | PHARMACY | 16 | 19 |
| 20 SALE OF MEDICAL RECORDS AND ABSTRACTS | A | -2 | 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 | -435790 | NONPHYSICIAN ANESTHETISTS | 20 | 33 |
| 34 PHYSICIANS' ASSISTANT | | | | | 34 |
| 35 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST WKST A-8-4 | | OCCUPATIONAL THERAPY | 51 | 35 |
| 36 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL | WKST WKST A-8-4 | | SPEECH PATHOLOGY | 52 | 36 |
| 37 PROVISION FOR BAD DEBTS | A | -1907203 | ADMINISTRATIVE & ACCOUNTING | 6.01 | 37 |
| 38 DIETARY REVENUE | B | -27105 | DIETARY | 11 | 38 |
| 39 BUS OFFICE COSTS ASSOC W/ PHYS CH | A | -27347 | BUSINESS SERVICES | 6.02 | 39 |
| 40 TELEPHONE | A | -500 | NEW CAP REL COSTS-MVBLE EQUIP | 4 | 40 |
| 41 PHYSICIAN RECRUITMENT | A | -138301 | ADMINISTRATIVE & ACCOUNTING | 6.01 | 41 |
| 42 OTHER REVENUE | B | -179 | ADMINISTRATIVE & ACCOUNTING | 6.01 | 42 |
| 43 LOBBYING PORTION OF DUES | A | -11829 | ADMINISTRATIVE & ACCOUNTING | 6.01 | 43 |
| 44 MARKETING | A | -66957 | EMPLOYEE BENEFITS | 5 | 44 |
| 45 OTHER REVENUE | B | -807 | ADMINISTRATIVE & ACCOUNTING | 6.01 | 45 |
| 46 SPOUSE MEAL COST | A | -369 | ADMINISTRATIVE & ACCOUNTING | 6.01 | 46 |
| 47 ATHLETIC TRAINER | A | -408 | PHYSICAL THERAPY | 50 | 47 |
| 48 ADVERTISING | A | -75 | ADMINISTRATIVE & ACCOUNTING | 6.01 | 48 |
| 49 | | | | | 49 |
| 50 TOTAL | | -3640589 | | | 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:

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

| WKST A | COST CENTER/ PHYSICIAN IDENTIFIER | TOTAL REMUNERA- TION INCL FRINGES | PROFES- SIONAL COMPONENT | PROVIDER COMPONENT | RCE AMOUNT | PHYSICIAN/ PROVIDER COMPONENT HOURS | UNAD- JUSTED RCE LIMIT | PERCENT OF UNAD- JUSTED RCE LIMIT |
|-----------|--------------------------------------|--|--------------------------------|-----------------------|---------------|--|---------------------------------|--|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 1 | 37 OPERATING ROOM | | OR | | 24000 | | | |
| 2 | 44 LABORATORY | | LABORATORY | | 36000 | | | |
| 3 | 49 RESPIRATORY THERAPY | | RESPIRATORY THERAPY | | 70136 | | | |
| 4 | 49 RESPIRATORY THERAPY | | RESPIRATORY THERAPY | | 520 | | | |
| 5 | 53 ELECTROCARDIOLOGY | | ELECTROCARDIOLOGY | | 49715 | | | |
| 6 | 61 EMERGENCY | | EMERGENCY | | 1535461 | | | |
| 7 | 63.50 PHOTOS RHC | | RHC | | 797382 | | | |
| 101 | TOTAL | | | | 1715832 | | | |
| | | | | | | | | 833382 |

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

| WKST A | COST CENTER/ PHYSICIAN IDENTIFIER | COST OF MEMBERSHIP & CONTIN. EDUCATION | PROVIDER COMPONENT SHARE OF COLUMN 12 | PHYSICIAN COST OF MALPRACTICE INSURANCE | PROVIDER COMPONENT SHARE OF COLUMN 14 | ADJUSTED RCE LIMIT | RCE DIS- ALLOWANCE | ADJUST- MENT |
|-------------|--------------------------------------|---|--|--|--|--------------------------|--------------------------|-----------------|
| LINE NO. | | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 10 | 11 | | | | | | | |
| 1 | 37 OPERATING ROOM | | OR | | | | | 24000 |
| 2 | 44 LABORATORY | | LABORATORY | | | | | |
| 3 | 49 RESPIRATORY THERAPY | | RESPIRATORY THERAPY | | | | | 70136 |
| 4 | 49 RESPIRATORY THERAPY | | RESPIRATORY THERAPY | | | | | 520 |
| 5 | 53 ELECTROCARDIOLOGY | | ELECTROCARDIOLOGY | | | | | 49715 |
| 6 | 61 EMERGENCY | | EMERGENCY | | | | | 738079 |
| 7 | 63.50 PHOTOS RHC | | RHC | | | | | |
| 101 | TOTAL | | | | | | | 882450 |

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) | | | | | 8 | 1 |
| 2 | LINE 1 MULTIPLIED BY 15 HOURS PER WEEK | | | | | 120 | 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 | | 218.00 | | | | 9 |
| 10 | AHSEA | | 68.26 | | | | 10 |
| 11 | STANDARD TRAVEL ALLOWANCE | 34.13 | 34.13 | | | | 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 | | | | | 14881 | 15 |
| 16 | ASSISTANTS | | | | | | 16 |
| 17 | SUBTOTAL ALLOWANCE AMOUNT | | | | | 14881 | 17 |
| 18 | AIDES | | | | | | 18 |
| 19 | TRAINEES | | | | | | 19 |
| 20 | TOTAL ALLOWANCE AMOUNT | | | | | 14881 | 20 |
| 21 | WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES | | | | | | 21 |
| 22 | WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES | | | | | | 22 |
| 23 | TOTAL SALARY EQUIVALENCY | | | | | 14881 | 23 |

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

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 |

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

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 | | | | | | 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 | | | | | 14881 | 57 |
| 58 | | | | | | 58 |
| 59 | | | | | | 59 |
| 60 | | | | | | 60 |
| 61 | | | | | | 61 |
| 62 | | | | | | 62 |
| 63 | | | | | 14881 | 63 |
| 64 | | | | | 10251 | 64 |
| 65 | | | | | | 65 |

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
PERIOD FROM 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
08/02/2011 08:21

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 [] SPEECH PATHOLOGY

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

| | | | |
|----|---|----------|----|
| 66 | COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL | 10251 | 66 |
| 67 | TOTAL COST | 10251 | 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 |

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 1 | THERAPISTS 2 | ASSISTANTS 3 | AIDES 4 | TRAINEES 5 | |
|-------|------------------|-----------------|-----------------|------------|---------------|-------|
| 9 | | 5544.00 | | 4597.00 | | 9 |
| 10 | | 72.03 | | 52.32 | | 10 |
| 11 | 36.02 | 36.02 | | | | 11 |
| 12 | | | | | | 12 |
| 12.01 | | | | | | 12.01 |
| 13 | | | | | | 13 |
| 13.01 | | | | | | 13.01 |

PART II - SALARY EQUIVALENCY COMPUTATION

| | | | | | | | |
|----|--|--|--|--|--|--------|----|
| 14 | SUPERVISORS | | | | | | 14 |
| 15 | THERAPISTS | | | | | 399334 | 15 |
| 16 | ASSISTANTS | | | | | | 16 |
| 17 | SUBTOTAL ALLOWANCE AMOUNT | | | | | 399334 | 17 |
| 18 | AIDES | | | | | 240515 | 18 |
| 19 | TRAINEES | | | | | | 19 |
| 20 | TOTAL ALLOWANCE AMOUNT | | | | | 639849 | 20 |
| 21 | WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES | | | | | | 21 |
| 22 | WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES | | | | | | 22 |
| 23 | TOTAL SALARY EQUIVALENCY | | | | | 639849 | 23 |

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
PERIOD FROM 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
08/02/2011 08:21

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

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 |

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 | | | | | 639849 | 57 |
| 58 | | | | | | 58 |
| 59 | | | | | | 59 |
| 60 | | | | | | 60 |
| 61 | | | | | | 61 |
| 62 | | | | | | 62 |
| 63 | | | | | 639849 | 63 |
| 64 | | | | | 450331 | 64 |
| 65 | | | | | | 65 |

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
PERIOD FROM 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
08/02/2011 08:21

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

| | | | |
|----|---|----------|----|
| 66 | COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL | 450331 | 66 |
| 67 | TOTAL COST | 450331 | 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 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
 08/02/2011 08:21

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) | | | | | 22 | 1 |
| 2 | LINE 1 MULTIPLIED BY 15 HOURS PER WEEK | | | | | 330 | 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 | | 91.75 | | | | 9 |
| 10 | AHSEA | | 65.60 | | | | 10 |
| 11 | STANDARD TRAVEL ALLOWANCE | 32.80 | 32.80 | | | | 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 | | | | | 6019 | 15 |
| 16 | ASSISTANTS | | | | | | 16 |
| 17 | SUBTOTAL ALLOWANCE AMOUNT | | | | | 6019 | 17 |
| 18 | AIDES | | | | | | 18 |
| 19 | TRAINEES | | | | | | 19 |
| 20 | TOTAL ALLOWANCE AMOUNT | | | | | 6019 | 20 |
| 21 | WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES | | | | | 65.60 | 21 |
| 22 | WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES | | | | | 21648 | 22 |
| 23 | TOTAL SALARY EQUIVALENCY | | | | | 21648 | 23 |

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 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
 08/02/2011 08:21

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 | | | | | | 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 | | | | | 21648 | 57 |
| 58 | | | | | | 58 |
| 59 | | | | | | 59 |
| 60 | | | | | | 60 |
| 61 | | | | | | 61 |
| 62 | | | | | | 62 |
| 63 | | | | | 21648 | 63 |
| 64 | | | | | 5034 | 64 |
| 65 | | | | | | 65 |

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
PERIOD FROM 04/01/2010 TO 03/31/2011

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

VERSION: 2011.03
08/02/2011 08:21

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 SPEECH PATHOLOGY

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

| | | | |
|----|---|----------|----|
| 66 | COST OF OUTSIDE SUPPLIER SERVICES - HOSPITAL | 5034 | 66 |
| 67 | TOTAL COST | 5034 | 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 FOR COST ALLOCATION | NEW CAP BLDGS & FIXTURES | NEW CAP MOVABLE EQUIPMENT | EMPLOYEE BENEFITS | SUBTOTAL | ADMINISTRATIVE & ACCOUNTING | BUSINESS SERVICES | OPERATION OF PLANT | |
|---------------------------------------|-----------------------------|--------------------------|---------------------------|-------------------|----------|-----------------------------|-------------------|--------------------|-------|
| | 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 | 1042135 | 1042135 | | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | 1436258 | | 1436258 | | | | | | 4 |
| 5 EMPLOYEE BENEFITS | 1616436 | 5896 | 2380 | 1624712 | | | | | 5 |
| 6.01 ADMINISTRATIVE & ACCOUNTING | 1269747 | 284727 | 28021 | 108787 | 1691282 | 1691282 | | | 6.01 |
| 6.02 BUSINESS SERVICES | 978051 | 58855 | 138182 | 134270 | 1309358 | 122212 | 1431570 | | 6.02 |
| 7 MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 OPERATION OF PLANT | 968277 | 100116 | 41414 | 67416 | 1177223 | 109878 | | 1287101 | 8 |
| 9 LAUNDRY & LINEN SERVICE | 55775 | 9199 | 2784 | 8061 | 75819 | 7077 | | 19983 | 9 |
| 10 HOUSEKEEPING | 223592 | 8018 | 211 | 32231 | 264052 | 24646 | | 17417 | 10 |
| 11 DIETARY | 128572 | 29678 | 5954 | 13867 | 178071 | 16621 | | 64466 | 11 |
| 12 CAFETERIA | 352354 | | | 40988 | 393342 | 36713 | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | 69598 | 16642 | 5510 | 12192 | 103942 | 9702 | | 36150 | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | | | | | | | | 15 |
| 15.01 PURCHASING | 90425 | 14008 | 467 | 18574 | 123474 | 11525 | | 30428 | 15.01 |
| 15.02 CENTRAL SERVICES & SUPPLY | | | | | | | | | 15.02 |
| 16 PHARMACY | 1121399 | 7767 | 23 | 11211 | 1140400 | 106442 | | 16872 | 16 |
| 17 MEDICAL RECORDS & LIBRARY | 398567 | 18775 | 32168 | 48642 | 498152 | 46496 | | 40782 | 17 |
| 18 SOCIAL SERVICE | 51714 | | | 9867 | 61581 | 5748 | | | 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 | 1767098 | 57360 | 69424 | 352708 | 2246590 | 209686 | 91299 | 124596 | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 37 OPERATING ROOM | 872814 | 63580 | 203245 | 179885 | 1319524 | 123160 | 87566 | 138106 | 37 |
| 40 ANESTHESIOLOGY | | | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 1311085 | 35292 | 743211 | 97257 | 2186845 | 204114 | 472753 | 76660 | 41 |
| 44 LABORATORY | 1499787 | 64113 | 72687 | 125823 | 1762410 | 164498 | 329580 | 139265 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 441129 | 33881 | 29800 | 64098 | 568908 | 53100 | 82009 | 73595 | 49 |
| 50 PHYSICAL THERAPY | 825309 | 58781 | 8848 | | 892938 | 83344 | 71677 | 127684 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 62953 | | 6669 | 12849 | 82471 | 7698 | 20579 | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 608311 | 10036 | 414 | 3168 | 621929 | 58049 | 57697 | 21799 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | | 86998 | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 60 CLINIC | 149287 | 4600 | 373 | 29152 | 183412 | 17119 | 15338 | 9991 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | | | 60.01 |
| 61 EMERGENCY | 1673496 | 41501 | 32468 | 174557 | 1922022 | 179396 | 105329 | 90148 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 PHOTOS RHC | 658497 | 9827 | 423 | 60096 | 728843 | 68028 | 10745 | 21345 | 63.50 |
| 63.60 PQHC | | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 CMHC | | | | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | | | | | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 SUBTOTALS | 19672666 | 932652 | 1424676 | 1605699 | 19532588 | 1665252 | 1431570 | 1049287 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 GIFT, FLOWER, COFFEE SHOP & CAN | 99824 | 10872 | 5188 | 10870 | 126754 | 11831 | | 23616 | 96 |
| 98 PHYSICIANS' PRIVATE OFFICES | 38978 | 28654 | 6394 | 8143 | 82169 | 7669 | | 62241 | 98 |
| 98.01 TEMPORARILY IDLE SPACE | | 69957 | | | 69957 | 6530 | | 151957 | 98.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 TOTAL | 19811468 | 1042135 | 1436258 | 1624712 | 19811468 | 1691282 | 1431570 | 1287101 | 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 | CENTRAL SERVICES & SUPPLY 15.02 | PHARMACY 16 | |
|---------------------------------------|------------------------------|---------------------|---------------|-----------------|------------------------------|---------------------|------------------------------------|----------------|-------|
| GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 4 |
| 5 EMPLOYEE BENEFITS | | | | | | | | | 5 |
| 6.01 ADMINISTRATIVE & ACCOUNTING | | | | | | | | | 6.01 |
| 6.02 BUSINESS SERVICES | | | | | | | | | 6.02 |
| 7 MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 OPERATION OF PLANT | | | | | | | | | 8 |
| 9 LAUNDRY & LINEN SERVICE | 102879 | | | | | | | | 9 |
| 10 HOUSEKEEPING | 3102 | 309217 | | | | | | | 10 |
| 11 DIETARY | 764 | 2978 | 262900 | | | | | | 11 |
| 12 CAFETERIA | | | | 430055 | | | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | | | | 3389 | 153183 | | | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | | | | | | | | 15 |
| 15.01 PURCHASING | | | | 7022 | | 172449 | | | 15.01 |
| 15.02 CENTRAL SERVICES & SUPPLY | | | | | | 466 | 466 | | 15.02 |
| 16 PHARMACY | | 6769 | | 5660 | | 1814 | | 1277957 | 16 |
| 17 MEDICAL RECORDS & LIBRARY | | 2708 | | 24280 | | 1216 | | | 17 |
| 18 SOCIAL SERVICE | | | | 2655 | | 2 | | | 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 | 62779 | 119950 | 262900 | 123778 | 71737 | 12349 | | | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 37 OPERATING ROOM | 11380 | 37366 | | 40979 | 34919 | 21507 | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 9156 | 25723 | | 52822 | | 22289 | | | 41 |
| 44 LABORATORY | | 22745 | | 50377 | | 94968 | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | 6498 | | 26236 | | 4109 | | | 49 |
| 50 PHYSICAL THERAPY | 5067 | 12997 | | | | 2084 | 1 | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | 4603 | | | | 579 | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 333 | 6228 | | 2166 | | | 465 | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | | | 1277957 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 60 CLINIC | | | | 9223 | | 1660 | | | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | | | 60.01 |
| 61 EMERGENCY | 10298 | 35471 | | 52228 | 34067 | 7751 | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 PHOTOS RHC | | | | 19249 | 12460 | 831 | | | 63.50 |
| 63.60 FQHC | | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 CMHC | | | | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | | | | | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 SUBTOTALS | 102879 | 284036 | 262900 | 420064 | 153183 | 171625 | 466 | 1277957 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 GIFT, FLOWER, COFFEE SHOP & CAN | | | | 6393 | | 799 | | | 96 |
| 98 PHYSICIANS' PRIVATE OFFICES | | 25181 | | 3598 | | 25 | | | 98 |
| 98.01 TEMPORARILY IDLE SPACE | | | | | | | | | 98.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 TOTAL | 102879 | 309217 | 262900 | 430055 | 153183 | 172449 | 466 | 1277957 | 103 |

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

| COST CENTER DESCRIPTION | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | SUBTOTAL | I&R COST & POST STEP-DOWN ADJS | TOTAL | |
|---------------------------------------|---------------------------|----------------|----------|--------------------------------|----------|-------|
| | 17 | 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 | 613634 | | | | | 17 |
| 18 SOCIAL SERVICE | | 69986 | | | | 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 | 249141 | 69986 | 3644791 | | 3644791 | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 37 OPERATING ROOM | 39053 | | 1853560 | | 1853560 | 37 |
| 40 ANESTHESIOLOGY | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 53878 | | 3104240 | | 3104240 | 41 |
| 44 LABORATORY | 143193 | | 2707036 | | 2707036 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 25312 | | 839767 | | 839767 | 49 |
| 50 PHYSICAL THERAPY | 34352 | | 1230144 | | 1230144 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 9402 | | 125332 | | 125332 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | | | 768666 | | 768666 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | 1364955 | | 1364955 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60 CLINIC | | | 236743 | | 236743 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | 60.01 |
| 61 EMERGENCY | 53517 | | 2490227 | | 2490227 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | 62 |
| 63.50 PHOTOS RHC | 5786 | | 867287 | | 867287 | 63.50 |
| 63.60 PQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 69.10 CMHC | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | 85.03 |
| 95 SUBTOTALS | 613634 | 69986 | 19232748 | | 19232748 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | |
| 96 GIFT, FLOWER, COFFEE SHOP & CAN | | | 169393 | | 169393 | 96 |
| 98 PHYSICIANS' PRIVATE OFFICES | | | 180883 | | 180883 | 98 |
| 98.01 TEMPORARILY IDLE SPACE | | | 228444 | | 228444 | 98.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | 102 |
| 103 TOTAL | 613634 | 69986 | 19811468 | | 19811468 | 103 |

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

| COST CENTER DESCRIPTION | DIR ASSGND CAP-REL COSTS 0 | NEW CAP BLDGS & FIXTURES 3 | NEW CAP MOVABLE EQUIPMENT 4 | CAP REL COST TO BE ALLOC 4A | EMPLOYEE BENEFITS 5 | ADMINISTRA TIVE & ACC OUNTING 6.01 | BUSINESS SERVICES 6.02 | S 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 | | 5896 | 2380 | 8276 | 8276 | | | | 5 |
| 6.01 ADMINISTRATIVE & ACCOUNTING | | 284727 | 28021 | 312748 | 554 | 313302 | | | 6.01 |
| 6.02 BUSINESS SERVICES | | 58855 | 138182 | 197037 | 684 | 22639 | 220360 | | 6.02 |
| 7 MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 OPERATION OF PLANT | | 100116 | 41414 | 141530 | 343 | 20354 | | 162227 | 8 |
| 9 LAUNDRY & LINEN SERVICE | | 9199 | 2784 | 11983 | 41 | 1311 | | 2519 | 9 |
| 10 HOUSEKEEPING | | 8018 | 211 | 8229 | 164 | 4565 | | 2195 | 10 |
| 11 DIETARY | | 29678 | 5954 | 35632 | 71 | 3079 | | 8125 | 11 |
| 12 CAFETERIA | | | | | 209 | 6801 | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | | 16642 | 5510 | 22152 | 62 | 1797 | | 4556 | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | | | | | | | | 15 |
| 15.01 PURCHASING | | 14008 | 467 | 14475 | 95 | 2135 | | 3835 | 15.01 |
| 15.02 CENTRAL SERVICES & SUPPLY | | | | | | | | | 15.02 |
| 16 PHARMACY | | 7767 | 23 | 7790 | 57 | 19718 | | 2127 | 16 |
| 17 MEDICAL RECORDS & LIBRARY | | 18775 | 32168 | 50943 | 248 | 8613 | | 5140 | 17 |
| 18 SOCIAL SERVICE | | | | | 50 | 1065 | | | 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 | | 57360 | 69424 | 126784 | 1798 | 38845 | 14053 | 15704 | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 37 OPERATING ROOM | | 63580 | 203245 | 266825 | 916 | 22815 | 13479 | 17407 | 37 |
| 40 ANESTHESIOLOGY | | | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | 35292 | 743211 | 778503 | 495 | 37811 | 72774 | 9662 | 41 |
| 44 LABORATORY | | 64113 | 72687 | 136800 | 641 | 30472 | 50730 | 17553 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | 33881 | 29800 | 63681 | 327 | 9836 | 12623 | 9276 | 49 |
| 50 PHYSICAL THERAPY | | 58781 | 8848 | 67629 | | 15439 | 11033 | 16093 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | | 6669 | 6669 | 65 | 1426 | 3168 | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | | 10036 | 414 | 10450 | 16 | 10753 | 8881 | 2748 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | | 13391 | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 60 CLINIC | | 4600 | 373 | 4973 | 149 | 3171 | 2361 | 1259 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | | | 60.01 |
| 61 EMERGENCY | | 41501 | 32468 | 73969 | 889 | 33232 | 16213 | 11362 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 PHOTOS RHC | | 9827 | 423 | 10250 | 306 | 12602 | 1654 | 2690 | 63.50 |
| 63.60 FQHC | | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 CMHC | | | | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | | | | | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 SUBTOTALS | | 932652 | 1424676 | 2357328 | 8180 | 308479 | 220360 | 132251 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 GIFT, FLOWER, COFFEE SHOP & CAN | | 10872 | 5188 | 16060 | 55 | 2192 | | 2977 | 96 |
| 98 PHYSICIANS' PRIVATE OFFICES | | 28654 | 6394 | 35048 | 41 | 1421 | | 7845 | 98 |
| 98.01 TEMPORARILY IDLE SPACE | | 69957 | | 69957 | | 1210 | | 19154 | 98.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 TOTAL | | 1042135 | 1436258 | 2478393 | 8276 | 313302 | 220360 | 162227 | 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 | CENTRAL SERVICES & SUPPLY 15.02 | PHARMACY 16 | |
|---------------------------------------|------------------------------|---------------------|---------------|-----------------|------------------------------|---------------------|------------------------------------|----------------|-------|
| GENERAL SERVICE COST CENTERS | | | | | | | | | |
| 1 OLD CAP REL COSTS-BLDG & FIXT | | | | | | | | | 1 |
| 2 OLD CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 2 |
| 3 NEW CAP REL COSTS-BLDG & FIXT | | | | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | | | | | | | | | 4 |
| 5 EMPLOYEE BENEFITS | | | | | | | | | 5 |
| 6.01 ADMINISTRATIVE & ACCOUNTING | | | | | | | | | 6.01 |
| 6.02 BUSINESS SERVICES | | | | | | | | | 6.02 |
| 7 MAINTENANCE & REPAIRS | | | | | | | | | 7 |
| 8 OPERATION OF PLANT | | | | | | | | | 8 |
| 9 LAUNDRY & LINEN SERVICE | 15854 | | | | | | | | 9 |
| 10 HOUSEKEEPING | 478 | 15631 | | | | | | | 10 |
| 11 DIETARY | 118 | 151 | 47176 | | | | | | 11 |
| 12 CAFETERIA | | | | 7010 | | | | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | | | | | 55 | 28622 | | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | | | | | | | | 15 |
| 15.01 PURCHASING | | | | 114 | | 20654 | | | 15.01 |
| 15.02 CENTRAL SERVICES & SUPPLY | | | | | | | 56 | | 15.02 |
| 16 PHARMACY | | 342 | | | 92 | 217 | | 30343 | 16 |
| 17 MEDICAL RECORDS & LIBRARY | | 137 | | | 396 | 146 | | | 17 |
| 18 SOCIAL SERVICE | | | | | 43 | | | | 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 | 9674 | 6063 | 47176 | 2019 | 13404 | 1479 | | | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 37 OPERATING ROOM | 1754 | 1889 | | | 668 | 6525 | 2576 | | 37 |
| 40 ANESTHESIOLOGY | | | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 1411 | 1300 | | | 861 | 2670 | | | 41 |
| 44 LABORATORY | | 1150 | | | 821 | 11374 | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | 328 | | | 428 | 492 | | | 49 |
| 50 PHYSICAL THERAPY | 781 | 657 | | | | 250 | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | 233 | | | | 69 | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 51 | 315 | | | 35 | | 56 | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | | | 30343 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 60 CLINIC | | | | | 150 | 199 | | | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | | | 60.01 |
| 61 EMERGENCY | 1587 | 1793 | | | 851 | 6365 | 928 | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | | | | 62 |
| 63.50 PHOTOS RHC | | | | | 314 | 2328 | 99 | | 63.50 |
| 63.60 PQHC | | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 69.10 CMHC | | | | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | | | | | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | | | | 85.03 |
| 95 SUBTOTALS | 15854 | 14358 | 47176 | 6847 | 28622 | 20555 | 56 | 30343 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | | | |
| 96 GIFT, FLOWER, COFFEE SHOP & CAN | | | | | 104 | 96 | | | 96 |
| 98 PHYSICIANS' PRIVATE OFFICES | | 1273 | | | 59 | 3 | | | 98 |
| 98.01 TEMPORALLY IDLE SPACE | | | | | | | | | 98.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | | | 102 |
| 103 TOTAL | 15854 | 15631 | 47176 | 7010 | 28622 | 20654 | 56 | 30343 | 103 |

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B
 PART III

| COST CENTER DESCRIPTION | MEDICAL RECORDS & LIBRARY | SOCIAL SERVICE | SUBTOTAL | I&R COST & POST STEP-DOWN ADJS | TOTAL | |
|---------------------------------------|---------------------------|----------------|----------|--------------------------------|---------|-------|
| | 17 | 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 | 65623 | | | | | 17 |
| 18 SOCIAL SERVICE | | 1158 | | | | 18 |
| 20 NONPHYSICIAN ANESTHETISTS | | | | | | 20 |
| 21 NURSING SCHOOL | | | | | | 21 |
| 22 I&P 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 | 26644 | 1158 | 304801 | | 304801 | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 37 OPERATING ROOM | 4176 | | 339030 | | 339030 | 37 |
| 40 ANESTHESIOLOGY | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 5762 | | 911249 | | 911249 | 41 |
| 44 LABORATORY | 15313 | | 264854 | | 264854 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | |
| 49 RESPIRATORY THERAPY | 2707 | | 99698 | | 99698 | 49 |
| 50 PHYSICAL THERAPY | 3674 | | 115556 | | 115556 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 1005 | | 12635 | | 12635 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | | | 33305 | | 33305 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | 43734 | | 43734 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60 CLINIC | | | 12262 | | 12262 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | |
| 61 EMERGENCY | 5723 | | 152912 | | 152912 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | | | | | 62 |
| 63.50 PHOTOS RHC | 619 | | 30862 | | 30862 | 63.50 |
| 63.60 FQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 69.10 CMHC | | | | | | 69.10 |
| 69.20 OUTPATIENT PHYSICAL THERAPY | | | | | | 69.20 |
| 69.30 OUTPATIENT OCCUPATIONAL THERAPY | | | | | | 69.30 |
| 69.40 OUTPATIENT SPEECH PATHOLOGY | | | | | | 69.40 |
| 71 HOME HEALTH AGENCY | | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 85.01 PANCREAS ACQUISITION | | | | | | 85.01 |
| 85.02 INTESTINAL ACQUISITION | | | | | | 85.02 |
| 85.03 ISLET CELL ACQUISITION | | | | | | 85.03 |
| 95 SUBTOTALS | 65623 | 1158 | 2320898 | | 2320898 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | |
| 96 GIFT, FLOWER, COFFEE SHOP & CAN | | | 21484 | | 21484 | 96 |
| 98 PHYSICIANS' PRIVATE OFFICES | | | 45690 | | 45690 | 98 |
| 98.01 TEMPORARILY IDLE SPACE | | | 90321 | | 90321 | 98.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | 102 |
| 103 TOTAL | 65623 | 1158 | 2478393 | | 2478393 | 103 |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| COST CENTER DESCRIPTION | 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 | |
|-------------------------------------|--|--|---|---------------------|--|--|-------|
| | 3 | 4 | 5 | 6A.01 | 6.01 | 6.02 | |
| 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 | 99690 | | | | | | 3 |
| 4 NEW CAP REL COSTS-MVBLE EQUIP | | 1436754 | | | | | 4 |
| 5 EMPLOYEE BENEFITS | | 2381 | 7116702 | | | | 5 |
| 6.01 ADMINISTRATIVE & ACCOUNTING | 27237 | 28031 | 476519 | -1691282 | 18120186 | | 6.01 |
| 6.02 BUSINESS SERVICES | 5630 | 138230 | 588140 | | 1309358 | 45490668 | 6.02 |
| 7 MAINTENANCE & REPAIRS | | | | | | | 7 |
| 8 OPERATION OF PLANT | 9577 | 41428 | 295301 | | 1177223 | | 8 |
| 9 LAUNDRY & LINEN SERVICE | 880 | 2785 | 35308 | | 75819 | | 9 |
| 10 HOUSEKEEPING | 767 | 211 | 141179 | | 264052 | | 10 |
| 11 DIETARY | 2839 | 5956 | 60743 | | 178071 | | 11 |
| 12 CAFETERIA | | | 179539 | | 393342 | | 12 |
| 13 MAINTENANCE OF PERSONNEL | | | | | | | 13 |
| 14 NURSING ADMINISTRATION | 1592 | 5512 | 53406 | | 103942 | | 14 |
| 15 CENTRAL SERVICES & SUPPLY | | | | | | | 15 |
| 15.01 PURCHASING | 1340 | 467 | 81358 | | 123474 | | 15.01 |
| 15.02 CENTRAL SERVICES & SUPPLY | | | | | | | 15.02 |
| 16 PHARMACY | 743 | 23 | 49107 | | 1140400 | | 16 |
| 17 MEDICAL RECORDS & LIBRARY | 1796 | 32179 | 213065 | | 498152 | | 17 |
| 18 SOCIAL SERVICE | | | 43219 | | 61581 | | 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 | 5487 | 69448 | 1544967 | | 2246590 | 2901144 | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | 6082 | 203315 | 787946 | | 1319524 | 2782535 | 37 |
| 40 ANESTHESIOLOGY | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 3376 | 743469 | 426014 | | 2186845 | 15023028 | 41 |
| 44 LABORATORY | 6133 | 72712 | 551139 | | 1762410 | 10472823 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 3241 | 29810 | 280769 | | 568908 | 2605957 | 49 |
| 50 PHYSICAL THERAPY | 5623 | 8851 | | | 892938 | 2277617 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | 6671 | 56283 | | 82471 | 653911 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | 960 | 414 | 13877 | | 621929 | 1833399 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | | | | | 2764472 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 60 CLINIC | 440 | 373 | 127695 | | 183412 | 487375 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | 60.01 |
| 61 EMERGENCY | 3970 | 32479 | 764608 | | 1922022 | 3346977 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | | | | | | 62 |
| 63.50 PHOTOS RHC | 940 | 423 | 263237 | | 728843 | 341430 | 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 | 89217 | 1425168 | 7033419 | -1691282 | 17841306 | 45490668 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | | | |
| 96 GIFT, FLOWER, COFFEE SHOP & C | 1040 | 5190 | 47615 | | 126754 | | 96 |
| 98 PHYSICIANS' PRIVATE OFFICES | 2741 | 6396 | 35668 | | 82169 | | 98 |
| 98.01 TEMPORARILY IDLE SPACE | 6692 | | | | 69957 | | 98.01 |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| COST CENTER DESCRIPTION | | 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 | |
|-------------------------|-------------------------------|--|--|---|---------------------|--|--|-----|
| | | 3 | 4 | 5 | 6A.01 | 6.01 | 6.02 | |
| 101 | CROSS FOOT ADJUSTMENTS | | | | | | | 101 |
| 102 | NEGATIVE COST CENTER | | | | | | | 102 |
| 103 | COST TO BE ALLOC PER B PT I | 1042135 | 1436258 | 1624712 | | 1691282 | 1431570 | 103 |
| 104 | UNIT COST MULT-WS B PT I | | .999655 | | | | .031470 | |
| 104 | UNIT COST MULT-WS B PT I | 10.453757 | | .228296 | | .093337 | | 104 |
| 105 | COST TO BE ALLOC PER B PT II | | | | | | | 104 |
| 106 | UNIT COST MULT-WS B PT II | | | | | | | 105 |
| 106 | UNIT COST MULT-WS B PT II | | | | | | | 106 |
| 107 | COST TO BE ALLOC PER B PT III | | | 8276 | | 313302 | 220360 | 106 |
| 108 | UNIT COST MULT-WS B PT III | | | | | | .004844 | 107 |
| 108 | UNIT COST MULT-WS B PT III | | | .001163 | | .017290 | | 108 |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| COST CENTER DESCRIPTION | OPERATION OF PLANT | LAUNDRY & LINEN SERVICE | HOUSE-KEEPING | DIETARY | CAFETERIA | NURSING ADMINISTRATION | PURCHASING |
|-------------------------------------|--------------------|-------------------------|------------------|--------------|--------------|------------------------|----------------|
| | SQUARE FEET | POUNDS OF LAUNDRY | HOURS OF SERVICE | MEALS SERVED | MEALS SERVED | DIRECT NRSING HRS | COSTED REQUIS. |
| | 8 | 9 | 10 | 11 | 12 | 14 | 15.01 |
| GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | | | | | | | 1 |
| 2 | | | | | | | 2 |
| 3 | | | | | | | 3 |
| 4 | | | | | | | 4 |
| 5 | | | | | | | 5 |
| 6.01 | | | | | | | 6.01 |
| 6.02 | | | | | | | 6.02 |
| 7 | | | | | | | 7 |
| 8 | 56682 | | | | | | 8 |
| 9 | 880 | 20730 | | | | | 9 |
| 10 | 767 | 625 | 1142 | | | | 10 |
| 11 | 2839 | 154 | 11 | 9987 | | | 11 |
| 12 | | | | | 12310 | | 12 |
| 13 | | | | | | | 13 |
| 14 | 1592 | | | | 97 | 139983 | 14 |
| 15 | | | | | | | 15 |
| 15.01 | 1340 | | | | 201 | | 1218468 |
| 15.02 | | | | | | | 3293 |
| 16 | 743 | | 25 | | 162 | | 12819 |
| 17 | 1796 | | 10 | | 695 | | 8595 |
| 18 | | | | | 76 | | 15 |
| 20 | | | | | | | |
| 21 | | | | | | | |
| 22 | | | | | | | |
| 23 | | | | | | | |
| 24 | | | | | | | |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 25 | 5487 | 12650 | 443 | 9987 | 3543 | 65556 | 87254 |
| 26 | | | | | | | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 | 6082 | 2293 | 138 | | 1173 | 31910 | 151960 |
| 40 | | | | | | | |
| 41 | 3376 | 1845 | 95 | | 1512 | | 157487 |
| 44 | 6133 | | 84 | | 1442 | | 671012 |
| 46.30 | | | | | | | |
| 49 | 3241 | | 24 | | 751 | | 29030 |
| 50 | 5623 | 1021 | 48 | | | | 14722 |
| 51 | | | | | | | |
| 52 | | | | | | | |
| 53 | | | 17 | | | | 4090 |
| 55 | 960 | 67 | 23 | | 62 | | |
| 56 | | | | | | | |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 60 | 440 | | | | 264 | | 11726 |
| 60.01 | | | | | | | |
| 61 | 3970 | 2075 | 131 | | 1495 | 31131 | 54769 |
| 62 | | | | | | | |
| 63.50 | 940 | | | | 551 | 11386 | 5869 |
| 63.60 | | | | | | | |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 69.10 | | | | | | | |
| 69.20 | | | | | | | |
| 69.30 | | | | | | | |
| 69.40 | | | | | | | |
| 71 | | | | | | | |
| SPECIAL PURPOSE COST CENTERS | | | | | | | |
| 85.01 | | | | | | | |
| 85.02 | | | | | | | |
| 85.03 | | | | | | | |
| 95 | 46209 | 20730 | 1049 | 9987 | 12024 | 139983 | 1212641 |
| NONREIMBURSABLE COST CENTERS | | | | | | | |
| 96 | 1040 | | | | 183 | | 5649 |
| 98 | 2741 | | 93 | | 103 | | 178 |
| 98.01 | 6692 | | | | | | |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| COST CENTER DESCRIPTION | OPERATION | LAUNDRY | HOUSE- | DIETARY | CAFETERIA | NURSING | PURCHASING | |
|-----------------------------------|-----------|-----------|------------|-----------|-----------|------------|------------|-----|
| | OF PLANT | & LINEN | KEEPING | | | ADMINIS- | | |
| | SQUARE | POUNDS OF | HOURS OF | MEALS | MEALS | DIRECT | COSTED | |
| | FEET | LAUNDRY | SERVICE | SERVED | SERVED | NRSING HRS | REQUIS. | |
| | 8 | 9 | 10 | 11 | 12 | 14 | 15.01 | |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | | 102 |
| 103 COST TO BE ALLOC PER B PT I | 1287101 | 102879 | 309217 | 262900 | 430055 | 153183 | 172449 | 103 |
| 104 UNIT COST MULT-WS B PT I | 22.707403 | | 270.767951 | | 34.935418 | | .141529 | |
| 104 UNIT COST MULT-WS B PT I | | 4.962808 | | 26.324221 | | 1.094297 | | 104 |
| 105 COST TO BE ALLOC PER B PT II | | | | | | | | 104 |
| 106 UNIT COST MULT-WS B PT II | | | | | | | | 105 |
| 106 UNIT COST MULT-WS B PT II | | | | | | | | 106 |
| 107 COST TO BE ALLOC PER B PT III | 162227 | 15854 | 15631 | 47176 | 7010 | 28622 | 20654 | 106 |
| 108 UNIT COST MULT-WS B PT III | 2.862055 | | 13.687391 | | .569456 | | .016951 | 107 |
| 108 UNIT COST MULT-WS B PT III | | .764785 | | 4.723741 | | .204468 | | 108 |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| COST CENTER DESCRIPTION | CENTRAL SERVICES & SUPPLY COSTED REQ UIS. | PHARMACY COSTED REQUIS. | MEDICAL RECORDS & LIBRARY TIME SPENT | SOCIAL SERVICE TIME SPENT | |
|-------------------------------------|---|-------------------------|--------------------------------------|---------------------------|-------|
| | 15.02 | 16 | 17 | 18 | |
| GENERAL SERVICE COST CENTERS | | | | | |
| 1 | | | | | 1 |
| 2 | | | | | 2 |
| 3 | | | | | 3 |
| 4 | | | | | 4 |
| 5 | | | | | 5 |
| 6.01 | | | | | 6.01 |
| 6.02 | | | | | 6.02 |
| 7 | | | | | 7 |
| 8 | | | | | 8 |
| 9 | | | | | 9 |
| 10 | | | | | 10 |
| 11 | | | | | 11 |
| 12 | | | | | 12 |
| 13 | | | | | 13 |
| 14 | | | | | 14 |
| 15 | | | | | 15 |
| 15.01 | | | | | 15.01 |
| 15.02 | 572103 | | | | 15.02 |
| 16 | | 100 | | | 16 |
| 17 | | | 1697 | | 17 |
| 18 | | | | 3757 | 18 |
| 20 | | | | | 20 |
| 21 | | | | | 21 |
| 22 | | | | | 22 |
| 23 | | | | | 23 |
| 24 | | | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | |
| 25 | | | 689 | 3757 | 25 |
| 26 | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 37 | | | 108 | | 37 |
| 40 | | | | | 40 |
| 41 | | | 149 | | 41 |
| 44 | | | 396 | | 44 |
| 46.30 | | | | | 46.30 |
| 49 | | | 70 | | 49 |
| 50 | 1225 | | 95 | | 50 |
| 51 | | | | | 51 |
| 52 | | | | | 52 |
| 53 | | | 26 | | 53 |
| 55 | 570822 | | | | 55 |
| 56 | | 100 | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | |
| 60 | | | | | 60 |
| 60.01 | | | | | 60.01 |
| 61 | | | 148 | | 61 |
| 62 | | | | | 62 |
| 63.50 | 56 | | 16 | | 63.50 |
| 63.60 | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | |
| 69.10 | | | | | 69.10 |
| 69.20 | | | | | 69.20 |
| 69.30 | | | | | 69.30 |
| 69.40 | | | | | 69.40 |
| 71 | | | | | 71 |
| SPECIAL PURPOSE COST CENTERS | | | | | |
| 85.01 | | | | | 85.01 |
| 85.02 | | | | | 85.02 |
| 85.03 | | | | | 85.03 |
| 95 | 572103 | 100 | 1697 | 3757 | 95 |
| NONREIMBURSABLE COST CENTERS | | | | | |
| 96 | | | | | 96 |
| 98 | | | | | 98 |
| 98.01 | | | | | 98.01 |

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

| COST CENTER DESCRIPTION | CENTRAL SERVICES & SUPPLY COSTED REQ UIS. | PHARMACY COSTED REQUIS. | MEDICAL RECORDS & LIBRARY TIME SPENT | SOCIAL SERVICE TIME SPENT | |
|-----------------------------------|---|-------------------------|--------------------------------------|---------------------------|-----|
| | 15.02 | 16 | 17 | 18 | |
| 101 CROSS FOOT ADJUSTMENTS | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | 102 |
| 103 COST TO BE ALLOC PER B PT I | 466 | 1277957 | 613634 | 69986 | 103 |
| 104 UNIT COST MULT-WS B PT I | .000815 | | 361.599293 | | |
| 104 UNIT COST MULT-WS B PT I | | 12779.570000 | | 18.628161 | 104 |
| 105 COST TO BE ALLOC PER B PT II | | | | | 104 |
| 106 UNIT COST MULT-WS B PT II | | | | | 105 |
| 106 UNIT COST MULT-WS B PT II | | | | | 106 |
| 107 COST TO BE ALLOC PER B PT III | 56 | 30343 | 65623 | 1158 | 106 |
| 108 UNIT COST MULT-WS B PT III | .000098 | | 38.670006 | | 107 |
| 108 UNIT COST MULT-WS B PT III | | 303.430000 | | .308225 | 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 | |
|-------------------------------------|---|-------------------------------------|---------------------|--------------------------|---------------------|-------|
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | |
| 25 ADULTS & PEDIATRICS | 3644791 | | 3644791 | | 3644791 | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 37 OPERATING ROOM | 1853560 | | 1853560 | | 1853560 | 37 |
| 40 ANESTHESIOLOGY | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 3104240 | | 3104240 | | 3104240 | 41 |
| 44 LABORATORY | 2707036 | | 2707036 | | 2707036 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMI | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 839767 | | 839767 | | 839767 | 49 |
| 50 PHYSICAL THERAPY | 1230144 | | 1230144 | | 1230144 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 125332 | | 125332 | | 125332 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO | 768666 | | 768666 | | 768666 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | 1364955 | | 1364955 | | 1364955 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60 CLINIC | 236743 | | 236743 | | 236743 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | 60.01 |
| 61 EMERGENCY | 2490227 | | 2490227 | | 2490227 | 61 |
| 62 OBSERVATION BEDS (NON-DISTI | 159558 | | 159558 | | 159558 | 62 |
| 63.50 PHOTOS RHC | 867287 | | 867287 | | 867287 | 63.50 |
| 63.60 FQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101 SUBTOTAL | 19392306 | | 19392306 | | 19392306 | 101 |
| 102 LESS OBSERVATION BEDS | 159558 | | 159558 | | 159558 | 102 |
| 103 TOTAL | 19232748 | | 19232748 | | 19232748 | 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 | 2901144 | | 2901144 | | | 25 |
| 26 INTENSIVE CARE UNIT | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | |
| 37 OPERATING ROOM | 439412 | 2343123 | 2782535 | .666141 | .666141 | .666141 37 |
| 40 ANESTHESIOLOGY | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 1464132 | 13558896 | 15023028 | .206632 | .206632 | .206632 41 |
| 44 LABORATORY | 1883161 | 8589662 | 10472823 | .258482 | .258482 | .258482 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMI | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 1089878 | 1516079 | 2605957 | .322249 | .322249 | .322249 49 |
| 50 PHYSICAL THERAPY | 213166 | 2064451 | 2277617 | .540101 | .540101 | .540101 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 79657 | 574254 | 653911 | .191665 | .191665 | .191665 53 |
| 55 MEDICAL SUPPLIES CHARGED TO | 953648 | 879751 | 1833399 | .419257 | .419257 | .419257 55 |
| 56 DRUGS CHARGED TO PATIENTS | 1276141 | 1488331 | 2764472 | .493749 | .493749 | .493749 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60 CLINIC | 988 | 486387 | 487375 | .485751 | .485751 | .485751 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | 60.01 |
| 61 EMERGENCY | 128097 | 3218880 | 3346977 | .744023 | .744023 | .744023 61 |
| 62 OBSERVATION BEDS (NON-DISTI | | 103707 | 103707 | 1.538546 | 1.538546 | 1.538546 62 |
| 63.50 PHOTOS RHC | | 341430 | 341430 | 2.540161 | 2.540161 | 2.540161 63.50 |
| 63.60 FQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 101 SUBTOTAL | 10429424 | 35164951 | 45594375 | | | 101 |
| 102 LESS OBSERVATION BEDS | | | | | | 102 |
| 103 TOTAL | 10429424 | 35164951 | 45594375 | | | 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 | | DIAGNOSTIC |
| | | | | CENTER | | |
| | | | | 2 | 3 | 4 |
| 37 ANCILLARY SERVICE COST CENTERS | | | | | | |
| OPERATING ROOM | .666141 | .666141 | .666141 | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | .206632 | .206632 | .206632 | | | 41 |
| 44 LABORATORY | .258482 | .258482 | .258482 | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | .322249 | .322249 | .322249 | | | 49 |
| 50 PHYSICAL THERAPY | .540101 | .540101 | .540101 | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | .191665 | .191665 | .191665 | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | .419257 | .419257 | .419257 | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | .493749 | .493749 | .493749 | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 60 CLINIC | .485751 | .485751 | .485751 | | | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | 60.01 |
| 61 EMERGENCY | .744023 | .744023 | .744023 | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | 1.538546 | 1.538546 | 1.538546 | | | 62 |
| 63.50 PHOTOS RHC | 2.540161 | 2.540161 | 2.540161 | | | 63.50 |
| 63.60 FQHC | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 65.01 AMBULANCE SERVICES (2ND PERIOD) | | | | | | 65.01 |
| 65.02 AMBULANCE SERVICES (3RD PERIOD) | | | | | | 65.02 |
| 65.03 AMBULANCE CHARGES (S-2 LINE 56. | | | | | | 65.03 |
| 101 SUBTOTAL | | | | | | 101 |
| 102 CRNA CHARGES | | | | | | 102 |
| 103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS | | | | | | 103 |
| 104 NET CHARGES | | | | | | 104 |

PART VI - VACCINE COST APPORTIONMENT

| | | |
|--|---------|------|
| 1 DRUGS CHARGED TO PATIENTS - RATIO OF COST TO CHARGES | .493749 | 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) | PPS SER- VICES | ALL OTHER (SEE INSTRU.) | PPS SER- VICES (SEE INSTRU.) | PPS SER- VICES (SEE INSTRU.) | OUTPATIENT AMBULATORY 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 | 1282345 | | | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 5550285 | | | | | | | 41 |
| 44 LABORATORY | 3472580 | | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN C | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 471745 | | | | | | | 49 |
| 50 PHYSICAL THERAPY | 806585 | | | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 409700 | | | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PA | 694529 | | | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | 996175 | | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | |
| 60 CLINIC | 241684 | | | | | | | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | | 60.01 |
| 61 EMERGENCY | 1209447 | | | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | 66884 | | | | | | | 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 | 15201959 | | | | | | | 101 |
| 102 CRNA CHARGES | | | | | | | | 102 |
| 103 FBP CLINIC LAB | | | | | | | | 103 |
| 104 NET CHARGES | 15201959 | | | | | | | 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) 9 | PPS SERVICES (COLUMNS 1.01x5.01) 1.01 | ALL OTHER (COLUMNS 1.01x5.02) 1.02 | PPS SERVICES (COLUMNS 1.01x5.03) 1.03 | PPS SERVICES (COLUMNS 1.01x5.04) 1.04 | I/P PART B CHARGES (SEE INSTRU.) 10 | I/P PART B COST (COLUMNS 1.02x10) 11 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | 854223 | | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | 1146866 | | | | | | 41 |
| 44 LABORATORY | 897599 | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | 152019 | | | | | | 49 |
| 50 PHYSICAL THERAPY | 435637 | | | | | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | 78525 | | | | | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 291186 | | | | | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | 491860 | | | | | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 60 CLINIC | 117398 | | | | | | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | 60.01 |
| 61 EMERGENCY | 899856 | | | | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT) | 102904 | | | | | | 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 | 5468073 | | | | | | 101 |
| 102 CRNA CHARGES | | | | | | | 102 |
| 103 LESS PBP CLINIC LAB SERV-PGM ONLY CHRGS | | | | | | | 103 |
| 104 NET CHARGES | 5468073 | | | | | | 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 1 | SWING-BED ADJUSTMENT 2 | REDUCED CAPITAL RELATED COST 3 | CAPITAL RELATED COST 4 | SWING-BED ADJUSTMENT 5 | REDUCED CAPITAL RELATED COST 6 |
| INPAT ROUTINE SERV COST CTRS | | | | | | |
| 25 ADULTS & PEDIATRICS | | | | 304801 | 8301 | 296500 |
| 26 INTENSIVE CARE UNIT | | | | | | |
| 27 CORONARY CARE UNIT | | | | | | |
| 28 BURN INTENSIVE CARE UNIT | | | | | | |
| 29 SURGICAL INTENSIVE CARE UNIT | | | | | | |
| 30 OTHER SPECIAL CARE (SPECIFY) | | | | | | |
| 31 SUBPROVIDER I | | | | | | |
| 33 NURSERY | | | | | | |
| 101 TOTAL | | | | 304801 | | 296500 |

| COST CENTER DESCRIPTION | OLD CAPITAL | | | NEW CAPITAL | | |
|---------------------------------|-------------------------|-----------------------------|---------------|--------------------------------------|----------------|--------------------------------------|
| | TOTAL PATIENT DAYS 7 | INPATIENT PROGRAM DAYS 8 | PER DIEM 9 | INPATIENT PROGRAM CAPITAL COST 10 | PER DIEM 11 | INPATIENT PROGRAM CAPITAL COST 12 |
| INPAT ROUTINE SERV COST CTRS | | | | | | |
| 25 ADULTS & PEDIATRICS | 3822 | 246 | | | 77.58 | 19085 |
| 26 INTENSIVE CARE UNIT | | | | | | |
| 27 CORONARY CARE UNIT | | | | | | |
| 28 BURN INTENSIVE CARE UNIT | | | | | | |
| 29 SURGICAL INTENSIVE CARE UNIT | | | | | | |
| 30 OTHER SPECIAL CARE (SPECIFY) | | | | | | |
| 31 SUBPROVIDER I | | | | | | |
| 33 NURSERY | | | | | | |
| 101 TOTAL | 3822 | 246 | | | | 19085 |

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D
 PART II

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

| COST CENTER DESCRIPTION | OLD | NEW | TOTAL | INPATIENT | ----- OLD CAPITAL ----- | | ----- NEW CAPITAL ----- | | |
|------------------------------------|---------|---------|----------|-----------|-------------------------|---------|-------------------------|---------|-------|
| | CAPITAL | CAPITAL | | | RATIO OF | CAPITAL | RATIO OF | CAPITAL | |
| | RELATED | RELATED | CHARGES | PROGRAM | COST TO | COSTS | COST TO | COSTS | |
| | COST | COST | | CHARGES | CHARGES | | CHARGES | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | | |
| 37 OPERATING ROOM | | 339030 | 2782535 | 82403 | | | .121842 | 10040 | 37 |
| 40 ANESTHESIOLOGY | | | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | 911249 | 15023028 | 211965 | | | .060657 | 12857 | 41 |
| 44 LABORATORY | | 264854 | 10472823 | 153121 | | | .025290 | 3872 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | 99698 | 2605957 | 50919 | | | .038258 | 1948 | 49 |
| 50 PHYSICAL THERAPY | | 115556 | 2277617 | 2445 | | | .050735 | 124 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | 12635 | 653911 | 8264 | | | .019322 | 160 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | 33305 | 1833399 | 60864 | | | .018166 | 1106 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | 43734 | 2764472 | 93108 | | | .015820 | 1473 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | | | |
| 60 CLINIC | | 12262 | 487375 | 935 | | | .025159 | 24 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | | | 60.01 |
| 61 EMERGENCY | | 152912 | 3346977 | 50925 | | | .045687 | 2327 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | | 103707 | | | | | | 62 |
| 63.50 PHOTOS RHC | | | 341430 | | | | | | 63.50 |
| 63.60 FQHC | | | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | | | |
| 101 TOTAL | | 1985235 | 42351801 | 714949 | | | | 33931 | 101 |

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART III

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

| COST CENTER DESCRIPTION | NONPHYSICIAN ANESTHETIST COST 1 | MEDICAL EDUCATION COST 2 | SWING-BED ADJUSTMENT AMOUNT 3 | TOTAL COSTS 4 | TOTAL PATIENT DAYS 5 | PER DIEM 6 | INPATIENT PROGRAM DAYS 7 | INPATIENT PROGRAM PASS THRU COSTS 8 |
|---------------------------------|--|-----------------------------------|--|---------------------|-------------------------------|------------------|-----------------------------------|---|
| INPAT ROUTINE SERV COST CTRS | | | | | | | | |
| 25 ADULTS & PEDIATRICS | | | | | 3822 | | 246 | 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 | | | | | 3822 | | 246 | 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 COST | NONPHYSICIAN ANESTHETIST COST | MEDICAL EDUCATION COST | | | | |
| | 1 | 1.01 | 2 | 2.01 | 2.02 | 2.03 | 3 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | | | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | | | | | | 41 |
| 44 LABORATORY | | | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | | | | | 49 |
| 50 PHYSICAL THERAPY | | | | | | | 50 |
| 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 | PROGRAM |
| | COSTS | CHARGES | CHARGES | TO CHARGES | CHARGES | PASS THROUGH | PROGRAM |
| | 3.01 | 4 | 5 | 5.01 | 6 | 7 | 8 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 OPERATING ROOM | | 2782535 | | | 82403 | | 37 |
| 40 ANESTHESIOLOGY | | | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | 15023028 | | | 211965 | | 41 |
| 44 LABORATORY | | 10472823 | | | 153121 | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | 2605957 | | | 50919 | | 49 |
| 50 PHYSICAL THERAPY | | 2277617 | | | 2445 | | 50 |
| 51 OCCUPATIONAL THERAPY | | | | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | | | | 52 |
| 53 ELECTROCARDIOLOGY | | 653911 | | | 8264 | | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO P | | 1833399 | | | 60864 | | 55 |
| 56 DRUGS CHARGED TO PATIENTS | | 2764472 | | | 93108 | | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | | |
| 60 CLINIC | | 487375 | | | 935 | | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | | | | 60.01 |
| 61 EMERGENCY | | 3346977 | | | 50925 | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINC | | 103707 | | | | | 62 |
| 63.50 PHOTOS RHC | | 341430 | | | | | 63.50 |
| 63.60 FQHC | | | | | | | 63.60 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 101 TOTAL | | 42351801 | | | 714949 | | 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 | OUTPATIENT | OUTPATIENT | OUTPATIENT | OUTPATIENT |
|------------------------------------|------------|------------|--------------|--------------|--------------|
| | PROGRAM | PROGRAM | PROGRAM | PROGRAM | PROGRAM |
| | CHARGES | CHARGES | PASS THROUGH | PASS THROUGH | PASS THROUGH |
| | 8.01 | 8.02 | COSTS | COSTS | COSTS |
| ANCILLARY SERVICE COST CENTERS | | | | | |
| 37 OPERATING ROOM | | | | | 37 |
| 40 ANESTHESIOLOGY | | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | | | | | 41 |
| 44 LABORATORY | | | | | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN | | | | | 46.30 |
| 49 RESPIRATORY THERAPY | | | | | 49 |
| 50 PHYSICAL THERAPY | | | | | 50 |
| 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) | 3929 | | | | | 1 |
| 2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS) | 3822 | | | | | 2 |
| 3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | | | | | | 3 |
| 4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | 3822 | | | | | 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 | 107 | | | | | 6 |
| 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 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) | 2835 | | | | | 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 | 107 | | | | | 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 | | | | | | | 20 |
| 21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST | 3644791 | | | | | | 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 | | | | | | | 24 |
| 25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 25 |
| 26 TOTAL SWING-BED COST | 99260 | | | | | | 26 |
| 27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST | 3545531 | | | | | | 27 |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | | | | |
| 28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES) | 2874164 | | | | | | 28 |
| 29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | | | | | | | 29 |
| 30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | 2874164 | | | | | | 30 |
| 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO | 1.233587 | | | | | | 31 |
| 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE | | | | | | | 32 |
| 33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE | 752.01 | | | | | | 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 | 3545531 | | | | | | 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 | 927.66 | | | | | 38 |
| 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 2629916 | | | | | 39 |
| 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM | | | | | | 40 |
| 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 2629916 | | | | | 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 |
| 43 INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS | | | | | | 43 |
| 44 INTENSIVE CARE UNIT | | | | | | 44 |
| 45 CORONARY CARE UNIT | | | | | | 45 |
| 46 BURN INTENSIVE CARE UNIT | | | | | | 46 |
| 47 SURGICAL INTENSIVE CARE UNIT | | | | | | 47 |
| 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 | 1740164 | | | | | 48 |
| 49 TOTAL PROGRAM INPATIENT COSTS | 4370080 | | | | | 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 | 1 | 1 | 1 | 1 | 1 | |
| 54 PROGRAM DISCHARGES | | | | | | 54 |
| 55 TARGET AMOUNT PER DISCHARGE | | | | | | 55 |
| 56 TARGET AMOUNT | | | | | | 56 |
| 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT | | | | | | 57 |
| 58 BONUS PAYMENT | | | | | | 58 |
| 58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET | | | | | | 58.01 |
| 58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET | | | | | | 58.02 |
| 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 | | | | | | 58.03 |
| 58.04 RELIEF PAYMENT | | | | | | 58.04 |
| 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT | | | | | | 59 |
| 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY) | | | | | | 59.01 |
| 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1 | | | | | | 59.02 |
| 59.03 PROGRAM DISCHARGES AFTER JULY 1 | | | | | | 59.03 |
| 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS) | | | | | | 59.04 |
| 59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1 | | | | | | 59.05 |
| 59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 | | | | | | 59.06 |
| 59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) | | | | | | 59.07 |
| 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.) | | | | | | 59.08 |
| PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| 60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | 99260 | | | | | 60 |
| 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 61 |
| 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS | 99260 | | | | | 62 |
| 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 63 |
| 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 64 |
| 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS | | | | | | 65 |

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 |

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 | |
|---|----------------------------------|-------|--------|---------|--------|--------|
| PART IV - COMPUTATION OF OBSERVATION BED COST | 1 | 1 | 1 | 1 | 1 | |
| 83 TOTAL OBSERVATION BEDS | | | | | | 172 |
| 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM | | | | | | 927.66 |
| 85 OBSERVATION BED COST | | | | | | 159558 |

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) | 3929 | | | | | | 1 |
| 2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS) | 3822 | | | | | | 2 |
| 3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | | | | | | | 3 |
| 4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS) | 3822 | | | | | | 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 | 107 | | | | | | 6 |
| 7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 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) | 246 | | | | | | 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 | | | | | | | 20 |
| 21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST | 3644791 | | | | | | 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 | | | | | | | 24 |
| 25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | | 25 |
| 26 TOTAL SWING-BED COST | 99260 | | | | | | 26 |
| 27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST | 3545531 | | | | | | 27 |
| PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | | | | | | | |
| 28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES) | 2874164 | | | | | | 28 |
| 29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | | | | | | | 29 |
| 30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES) | 2874164 | | | | | | 30 |
| 31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO | 1.233587 | | | | | | 31 |
| 32 AVERAGE PRIVATE ROOM PER DIEM CHARGE | | | | | | | 32 |
| 33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE | 752.01 | | | | | | 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 | 3545531 | | | | | | 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 | 927.66 | | | | | 38 |
| 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 228204 | | | | | 39 |
| 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM | | | | | | 40 |
| 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST | 228204 | | | | | 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 | 267417 | | | | | 48 |
| 49 TOTAL PROGRAM INPATIENT COSTS | 495621 | | | | | 49 |
| PASS THROUGH COST ADJUSTMENTS | | | | | | |
| 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES | 19085 | | | | | 50 |
| 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES | 33931 | | | | | 51 |
| 52 TOTAL PROGRAM EXCLUDABLE COST | 53016 | | | | | 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 | 1 | 1 | 1 | 1 | 1 | |
| 54 PROGRAM DISCHARGES | | | | | | 54 |
| 55 TARGET AMOUNT PER DISCHARGE | | | | | | 55 |
| 56 TARGET AMOUNT | | | | | | 56 |
| 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT | | | | | | 57 |
| 58 BONUS PAYMENT | | | | | | 58 |
| 58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET | | | | | | 58.01 |
| 58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET | | | | | | 58.02 |
| 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 | | | | | | 58.03 |
| 58.04 RELIEF PAYMENT | | | | | | 58.04 |
| 59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT | | | | | | 59 |
| 59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY) | | | | | | 59.01 |
| 59.02 PROGRAM DISCHARGES PRIOR TO JULY 1 | | | | | | 59.02 |
| 59.03 PROGRAM DISCHARGES AFTER JULY 1 | | | | | | 59.03 |
| 59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS) | | | | | | 59.04 |
| 59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1 | | | | | | 59.05 |
| 59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 | | | | | | 59.06 |
| 59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY) | | | | | | 59.07 |
| 59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.) | | | | | | 59.08 |
| PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| 60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 60 |
| 61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 61 |
| 62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS | | | | | | 62 |
| 63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 63 |
| 64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD | | | | | | 64 |
| 65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS | | | | | | 65 |

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 |

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 | 172 | 83 |
| 84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM | 927.66 | 84 |
| 85 OBSERVATION BED COST | 159558 | 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 | | 2205840 | | 25 |
| 26 INTENSIVE CARE UNIT | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | |
| 37 OPERATING ROOM | .666141 | 211246 | 140720 | 37 |
| 40 ANESTHESIOLOGY | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | .206632 | 1010967 | 208898 | 41 |
| 44 LABORATORY | .258482 | 1311897 | 339102 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 RESPIRATORY THERAPY | .322249 | 378569 | 121993 | 49 |
| 50 PHYSICAL THERAPY | .540101 | 140434 | 75849 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | 52 |
| 53 ELECTROCARDIOLOGY | .191665 | 55297 | 10598 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | .419257 | 875949 | 367248 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | .493749 | 957404 | 472717 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 60 CLINIC | .485751 | 50 | 24 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | 60.01 |
| 61 EMERGENCY | .744023 | 4052 | 3015 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | 1.538546 | | | 62 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 63.50 PHOTOS RHC | 2.540161 | | | 63.50 |
| 63.60 FQHC | | | | 63.60 |
| 101 TOTAL | | 4945865 | 1740164 | 101 |
| 102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 NET CHARGES | | 4945865 | | 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 | .666141 | | | 37 |
| 40 ANESTHESIOLOGY | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | .206632 | 2918 | 603 | 41 |
| 44 LABORATORY | .258482 | 16848 | 4355 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 RESPIRATORY THERAPY | .322249 | 11581 | 3732 | 49 |
| 50 PHYSICAL THERAPY | .540101 | 62447 | 33728 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | 52 |
| 53 ELECTROCARDIOLOGY | .191665 | 130 | 25 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | .419257 | 14918 | 6254 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | .493749 | 20070 | 9910 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 60 CLINIC | .485751 | | | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | 60.01 |
| 61 EMERGENCY | .744023 | | | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS | 1.538546 | | | 62 |
| 63.50 PHOTOS RHC | 2.540161 | | | 63.50 |
| 63.60 FQHC | | | | 63.60 |
| 101 TOTAL | | 128912 | 58607 | 101 |
| 102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 NET CHARGES | | 128912 | | 103 |

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

| | | | |
|---|--|----------------------------------|---|
| <input type="checkbox"/> TITLE V | <input checked="" type="checkbox"/> HOSPITAL (14-1345) | <input type="checkbox"/> SNF | <input type="checkbox"/> PPS |
| <input type="checkbox"/> TITLE XVIII-PT A | <input type="checkbox"/> SUB I | <input type="checkbox"/> NF | <input type="checkbox"/> TEFRA |
| <input checked="" type="checkbox"/> TITLE XIX | <input type="checkbox"/> SUB II | <input type="checkbox"/> S/B-SNF | <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 | | 176913 | | 25 |
| 26 INTENSIVE CARE UNIT | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | |
| 37 OPERATING ROOM | .666141 | 82403 | 54892 | 37 |
| 40 ANESTHESIOLOGY | | | | 40 |
| 41 RADIOLOGY-DIAGNOSTIC | .206632 | 211965 | 43799 | 41 |
| 44 LABORATORY | .258482 | 153121 | 39579 | 44 |
| 46.30 BLOOD CLOTTING FACTORS ADMIN CO | | | | 46.30 |
| 49 RESPIRATORY THERAPY | .322249 | 50919 | 16409 | 49 |
| 50 PHYSICAL THERAPY | .540101 | 2445 | 1321 | 50 |
| 51 OCCUPATIONAL THERAPY | | | | 51 |
| 52 SPEECH PATHOLOGY | | | | 52 |
| 53 ELECTROCARDIOLOGY | .191665 | 8264 | 1584 | 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | .419257 | 60864 | 25518 | 55 |
| 56 DRUGS CHARGED TO PATIENTS | .493749 | 93108 | 45972 | 56 |
| OUTPATIENT SERVICE COST CENTERS | | | | |
| 60 CLINIC | .485751 | 935 | 454 | 60 |
| 60.01 SALEM MEDICAL CLINIC | | | | 60.01 |
| 61 EMERGENCY | .744023 | 50925 | 37889 | 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | 1.538546 | | | 62 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 63.50 PHOTOS RHC | 2.540161 | | | 63.50 |
| 63.60 FQHC | | | | 63.60 |
| 101 TOTAL | | 714949 | 267417 | 101 |
| 102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES | | | | 102 |
| 103 NET CHARGES | | 714949 | | 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 | | | | 1 |
| 1.01 | | | | 1.01 |
| 1.02 | | | | 1.02 |
| 1.03 | | | | 1.03 |
| 1.04 | | | | 1.04 |
| 1.05 | | | | 1.05 |
| 1.06 | | | | 1.06 |
| 1.07 | | | | 1.07 |
| 1.08 | | | | 1.08 |
| 2 | | | | 2 |
| 2.01 | | | | 2.01 |
| 3 | | | | 3 |
| 3.01 | | | | 3.01 |
| 3.02 | | | | 3.02 |
| 3.03 | | | | 3.03 |
| 3.04 | | | | 3.04 |
| 3.05 | | | | 3.05 |
| 3.06 | | | | 3.06 |
| 3.07 | | 0.00 | 0.00 | 3.07 |
| 3.08 | | | | 3.08 |
| 3.09 | | | | 3.09 |
| 3.10 | | | | 3.10 |
| 3.11 | | | | 3.11 |
| 3.12 | | | | 3.12 |
| 3.13 | | | | 3.13 |
| 3.14 | | | | 3.14 |
| 3.15 | | | | 3.15 |
| 3.16 | | | | 3.16 |
| 3.17 | | 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 |
| | | | | | | [SUM OF LINES] [PLUS E-3,PT.VI] |
| | | | | | | [3.21-3.23] [LINE 23] |
| 3.24 | | | | | | 3.24 |
| | | | | | | DISPROPORTIONATE SHARE ADJUSTMENT |
| 4 | | | | | | 4 |
| | | | | | | PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS |
| 4.01 | | | | | | 4.01 |
| 4.02 | | | | | | 4.02 |
| 4.03 | | | | | | 4.03 |
| 4.04 | | | | | | 4.04 |
| | | | | | | ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES |
| 5 | | | | | | 5 |
| | | | | | | TOTAL MEDICARE DISCHARGES ON WKST S-3, PART I EXCLUDING DISCHARGES FOR DRGs 302, 316 AND 317 |
| 5.01 | | | | | | 5.01 |
| | | | | | | TOTAL ESRD MEDICARE DISCHARGES EXCLUDING DRGs 302, 316 AND 317 |
| 5.02 | | | | | | 5.02 |
| 5.03 | | | | | | 5.03 |
| | | | | | | DIVIDE LINE 5.01 BY LINE 5 |
| 5.04 | | | | | | 5.04 |
| | | | | | | TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING DRGs 302, 316 AND 317 |
| 5.05 | | | | | | 5.05 |
| | | | | | | RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK |
| 5.06 | | | | | | 5.06 |
| | | | | | | AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS |
| 6 | | | | | | 6 |
| | | | | | | TOTAL ADDITIONAL PAYMENT |
| 7 | | | | | | 7 |
| | | | | | | SUBTOTAL |
| 7.01 | | | | | | 7.01 |
| | | | | | | HOSPITAL SPECIFIC PAYMENTS |
| 8 | | | | | | 8 |
| | | | | | | HOSPITAL SPECIFIC PAYMENTS (1996 HSR) |
| 9 | | | | | | 9 |
| | | | | | | TOTAL PAYMENT FOR INPATIENT OPERATING COSTS |
| 10 | | | | | | 10 |
| | | | | | | PAYMENT FOR INPATIENT PROGRAM CAPITAL |
| 11 | | | | | | 11 |
| | | | | | | EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL |
| 11.01 | | | | | | 11.01 |
| | | | | | | DIRECT GRADUATE MEDICAL EDUCATION PAYMENT |
| 11.02 | | | | | | 11.02 |
| | | | | | | NURSING AND ALLIED HEALTH MANAGED CARE |
| 12 | | | | | | 12 |
| | | | | | | ADD-ON PAYMENT FOR NEW TECHNOLOGIES |
| 13 | | | | | | 13 |
| | | | | | | NET ORGAN ACQUISITION COST |
| 14 | | | | | | 14 |
| | | | | | | COST OF TEACHING PHYSICIANS |
| 15 | | | | | | 15 |
| | | | | | | ROUTINE SERVICE OTHER PASS THROUGH COSTS |
| 16 | | | | | | 16 |
| | | | | | | ANCILLARY SERVICE OTHER PASS THROUGH COSTS |
| 17 | | | | | | 17 |
| | | | | | | TOTAL |
| 18 | | | | | | 18 |
| | | | | | | PRIMARY PAYER PAYMENTS |
| 19 | | | | | | 19 |
| | | | | | | TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES |
| 20 | | | | | | 20 |
| | | | | | | DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES |
| 21 | | | | | | 21 |
| | | | | | | COINSURANCE BILLED TO PROGRAM BENEFICIARIES |
| 21.01 | | | | | | 21.01 |
| | | | | | | REIMBURSABLE BAD DEBTS |
| 21.02 | | | | | | 21.02 |
| | | | | | | REDUCED PROGRAM REIMBURSABLE BAD DEBTS |
| 22 | | | | | | 22 |
| | | | | | | REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES |
| | | | | | | SUBTOTAL |

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 |
| | | | | | | |
| 24 | | | | | | 24 |
| 25 | | | | | | 25 |
| 26 | | | | | | 26 |
| 27 | | | | | | 27 |
| 28 | | | | | | 28 |
| 28.01 | | | | | | 28.01 |
| 29 | | | | | | 29 |
| 30 | | | | | | 30 |
| | | | | | | |
| | | | | | | |
| 50 | | | | | | 50 |
| 51 | | | | | | 51 |
| 52 | | | | | | 52 |
| 53 | | | | | | 53 |
| 54 | | | | | | 54 |
| 55 | | | | | | 55 |
| 56 | | | | | | 56 |

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 | 5468073 | | | 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 | 5468073 | | | 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 | 5522754 | | | 17 |
| 17.01 TOTAL PPS PAYMENTS | | | | 17.01 |

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

| | HOSPITAL (14-1345) 1 | HOSPITAL (14-1345) 1.01 | HOSPITAL (14-1345) 1.02 |
|---|----------------------------|-------------------------------|-------------------------------|
| COMPUTATION OF REIMBURSEMENT SETTLEMENT | | | |
| 18 DEDUCTIBLES | 63611 | | 18 |
| 18.01 COINSURANCE | 2342014 | | 18.01 |
| 19 SUBTOTAL | 3117129 | | 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 | 3117129 | | 23 |
| 24 PRIMARY PAYER PAYMENTS | 246 | | 24 |
| 25 SUBTOTAL | 3116883 | | 25 |
| REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | | | |
| 26 COMPOSITE RATE ESRD | | | 26 |
| 27 BAD DEBTS | 617135 | | 27 |
| 27.01 REDUCED REIMBURSABLE BAD DEBTS | 617135 | | 27.01 |
| 27.02 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS) | 577678 | | 27.02 |
| 28 SUBTOTAL | 3734018 | | 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 | 3734018 | | 32 |
| 33 SEQUESTRATION ADJUSTMENT | | | 33 |
| 34 INTERIM PAYMENTS | 3537276 | | 34 |
| 34.01 TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | 34.01 |
| 35 BALANCE DUE PROVIDER/PROGRAM | 196742 | | 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 ADJUSTMENT AMOUNT (SEE INSTRUCTIONS) | | | 51 |
| 52 THE RATE USED TO CALCULATE THE TIME VALUE MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW | | | 52 |
| 53 TIME VALUE OF MONEY (SEE INSTRUCTIONS) | | | 53 |
| 54 FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 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 A | | PART B | | |
|--|--|---------------------------------------|-----------------|-------------|--|
| | MM/DD/YYYY 1 | AMOUNT 2 | MM/DD/YYYY 3 | AMOUNT 4 | |
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | 3452986 | | 3678501 | 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 PROGRAM .50 PROVIDER .51 TO .52 PROGRAM .53 .54 | 06/25/2010 90000 03/18/2011 221657 | | | 3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54 |
| SUBTOTAL | .99 | 189056 | | -141225 | 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | 3642042 | | 3537276 | 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 | 405167 | | 196742 | 6.01 6.02 |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | | 4047209 | | 3734018 | 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 A | | PART B | |
|--|------------------|-------------|----------------------------|-------------|
| | MM/DD/YYYY 1 | AMOUNT 2 | MM/DD/YYYY 3 | AMOUNT 4 |
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | 148522 | | 1 |
| 2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO. | | NONE | | NONE 2 |
| 3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM | | | | |
| ADJUSTMENT AMOUNT BASED ON SUBSEQUENT | PROGRAM | .01 | | 3.01 |
| REVISION OF THE INTERIM RATE FOR THE COST | TO | .02 | | 3.02 |
| REPORTING PERIOD. ALSO SHOW DATE OF EACH | PROVIDER | .03 | NONE | NONE 3.03 |
| PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM | .04 | | 3.04 |
| | | .05 | | 3.05 |
| | | .50 | | 3.50 |
| | PROVIDER | .51 | 09/24/2010 | 6027 3.51 |
| | TO | .52 | | NONE 3.52 |
| | PROGRAM | .53 | | 3.53 |
| | | .54 | | 3.54 |
| SUBTOTAL | | .99 | | -6027 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | | | 142495 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 |
| | PROGRAM | .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 | | 15713 6.01 |
| | PROGRAM TO | .02 | | 6.02 |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | | | | 158208 7 |
| NAME OF INTERMEDIARY: _____ | | | INTERMEDIARY NUMBER: _____ | |
| SIGNATURE OF AUTHORIZED PERSON: _____ | | | DATE (MO/DAY/YR): _____ | |

CALCULATION OF REIMBURSEMENT SETTLEMENT
 SWING BEDS

SUPPLEMENTAL
 WORKSHEET E-2

COMPUTATION OF NET COST OF COVERED SERVICES

| | TITLE V | --- TITLE XVIII --- | | --- TITLE XIX --- | | |
|-------|--|---------------------|---------|-------------------|--------|-------|
| | S/B NF | S/B SNF | S/B SNF | S/B SNF | S/B NF | |
| | 1 | (14-Z345) | | (14-Z345) | | |
| | | PART A | PART B | | | |
| | 1 | 1 | 2 | 1 | 1 | |
| 1 | INPATIENT ROUTINE SERVICES - SWING BED - SNF | | 100253 | | | 1 |
| 2 | INPATIENT ROUTINE SERVICES - SWING BED - NF | | | | | 2 |
| 3 | ANCILLARY SERVICES | | 59193 | | | 3 |
| 4 | PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM | | | | | 4 |
| 5 | PROGRAM DAYS | | 107 | | | 5 |
| 6 | INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM | | | | | 6 |
| 7 | UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY | | | | | 7 |
| 8 | SUBTOTAL | | 159446 | | | 8 |
| 9 | PRIMARY PAYER PAYMENTS | | | | | 9 |
| 10 | SUBTOTAL | | 159446 | | | 10 |
| 11 | DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMOUNTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES) | | | | | 11 |
| 12 | SUBTOTAL | | 159446 | | | 12 |
| 13 | COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES) | | 1238 | | | 13 |
| 14 | 80% OF PART B COSTS | | | | | 14 |
| 15 | SUBTOTAL | | 158208 | | | 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 | | 158208 | | | 18 |
| 19 | SEQUESTRATION ADJUSTMENT | | | | | 19 |
| 20 | INTERIM PAYMENTS | | 142495 | | | 20 |
| 20.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | | | 20.01 |
| 21 | BALANCE DUE PROVIDER/PROGRAM | | 15713 | | | 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 | | | | | 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 | 4370080 | | | | 4 |
| 5 | PRIMARY PAYER PAYMENTS | | | | 1531 | 5 |
| 6 | TOTAL COST | 4412234 | | | | 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 | | | | | | 18 |
| 19 | | | | | | 19 |
| 20 | 4412234 | | | | | 20 |
| 21 | 494053 | | | | | 21 |
| 22 | 3918181 | | | | | 22 |
| 23 | 3113 | | | | | 23 |
| 24 | 3915068 | | | | | 24 |
| 25 | 132141 | | | | | 25 |
| 25.01 | 132141 | | | | | 25.01 |
| 25.02 | 127177 | | | | | 25.02 |
| 26 | 4047209 | | | | | 26 |
| 27 | | | | | | 27 |
| 28 | | | | | | 28 |
| 29 | | | | | | 29 |
| 30 | 4047209 | | | | | 30 |
| 31 | | | | | | 31 |
| 32 | 3642042 | | | | | 32 |
| 32.01 | | | | | | 32.01 |
| 33 | 405167 | | | | | 33 |
| 34 | | | | | | 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 | INPATIENT HOSPITAL/SNF/NF SERVICES | 495621 | | | | 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 | 495621 | | | | 6 |
| 7 | INPATIENT PRIMARY PAYER PAYMENTS | | | | | 7 |
| 8 | OUTPATIENT PRIMARY PAYER PAYMENTS | | | | | 8 |
| 9 | SUBTOTAL | 495621 | | | | 9 |
| | COMPUTATION OF LESSER OF COST OR CHARGES | | | | | |
| 10 | ROUTINE SERVICE CHARGES | | | | | 10 |
| 11 | ANCILLARY SERVICE CHARGES | 714949 | | | | 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 | ACTUAL 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 | 495621 | | | | 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 | 495621 | | | | 30 |
| 31 | CUSTOMARY CHARGES (TITLE XIX PPS COVERED) | | | | | 31 |
| 32 | LESSER OF LINES 30 OR 31 | 495621 | | | | 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 | 495621 | | | | | 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 | 495621 | | | | | 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 | 495621 | | | | | 52 |
| 53 | INDIRECT MEDICAL EDUCATION ADJUSTMENT | | | | | | 53 |
| 54 | DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS | | | | | | 54 |
| 55 | TOTAL AMOUNT PAYABLE TO THE PROVIDER | 495621 | | | | | 55 |
| 56 | SEQUESTRATION ADJUSTMENT | | | | | | 56 |
| 57 | INTERIM PAYMENTS | | | | | | 57 |
| 57.01 | TENTATIVE SETTLEMENT (FOR FI USE ONLY) | | | | | | 57.01 |
| 58 | BALANCE DUE PROVIDER/PROGRAM | 495621 | | | | | 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 | 3018802 | | | 1 |
| 2 | TEMPORARY INVESTMENTS | | | | 2 |
| 3 | NOTES RECEIVABLE | | | | 3 |
| 4 | ACCOUNTS RECEIVABLE | 5088517 | | | 4 |
| 5 | OTHER RECEIVABLES | | | | 5 |
| 6 | ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE | -1972470 | | | 6 |
| 7 | INVENTORY | 362617 | | | 7 |
| 8 | PREPAID EXPENSES | 202203 | | | 8 |
| 9 | OTHER CURRENT ASSETS | 222033 | | | 9 |
| 10 | DUE FROM OTHER FUNDS | 129811 | | | 10 |
| 11 | TOTAL CURRENT ASSETS | 7051513 | | | 11 |
| FIXED ASSETS | | | | | |
| 12 | LAND | 61162 | | | 12 |
| 12.01 | ACCUMULATED DEPRECIATION | | | | 12.01 |
| 13 | LAND IMPROVEMENTS | 932114 | | | 13 |
| 13.01 | ACCUMULATED DEPRECIATION | -557271 | | | 13.01 |
| 14 | BUILDINGS | 21436374 | | | 14 |
| 14.01 | ACCUMULATED DEPRECIATION | -5922494 | | | 14.01 |
| 15 | LEASEHOLD IMPROVEMENTS | | | | 15 |
| 15.01 | ACCUMULATED AMORTIZATION | | | | 15.01 |
| 16 | FIXED EQUIPMENT | 1560753 | | | 16 |
| 16.01 | ACCUMULATED DEPRECIATION | -867528 | | | 16.01 |
| 17 | AUTOMOBILES AND TRUCKS | | | | 17 |
| 17.01 | ACCUMULATED DEPRECIATION | | | | 17.01 |
| 18 | MAJOR MOVABLE EQUIPMENT | 8925371 | | | 18 |
| 18.01 | ACCUMULATED DEPRECIATION | -5865198 | | | 18.01 |
| 19 | MINOR EQUIPMENT DEPRECIABLE | | | | 19 |
| 19.01 | ACCUMULATED DEPRECIATION | | | | 19.01 |
| 20 | MINOR EQUIPMENT-NONDEPRECIABLE | | | | 20 |
| 21 | TOTAL FIXED ASSETS | 19703283 | | | 21 |
| OTHER ASSETS | | | | | |
| 22 | INVESTMENTS | 4323661 | | | 22 |
| 23 | DEPOSITS ON LEASES | | | | 23 |
| 24 | DUE FROM OWNERS/OFFICERS | | | | 24 |
| 25 | OTHER ASSETS | 569601 | | | 25 |
| 26 | TOTAL OTHER ASSETS | 4893262 | | | 26 |
| 27 | TOTAL ASSETS | 31648058 | | | 27 |
| LIABILITIES AND FUND BALANCES | | | | | |
| | | GENERAL FUND | SPECIFIC PURPOSE FUND | ENDOWMENT FUND | PLANT FUND |
| | | 1 | 2 | 3 | 4 |
| CURRENT LIABILITIES | | | | | |
| 28 | ACCOUNTS PAYABLE | 857355 | | | 28 |
| 29 | SALARIES, WAGES & FEES PAYABLE | 874932 | | | 29 |
| 30 | PAYROLL TAXES PAYABLE | | | | 30 |
| 31 | NOTES & LOANS PAYABLE (SHORT TERM) | 130000 | | | 31 |
| 32 | DEFERRED INCOME | | | | 32 |
| 33 | ACCELERATED PAYMENTS | | | | 33 |
| 34 | DUE TO OTHER FUNDS | 157128 | | | 34 |
| 35 | OTHER CURRENT LIABILITIES | | | | 35 |
| 36 | TOTAL CURRENT LIABILITIES | 2019415 | | | 36 |
| LONG-TERM LIABILITIES | | | | | |
| 37 | MORTGAGE PAYABLE | 8199089 | | | 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 | 8199089 | | | 42 |
| 43 | TOTAL LIABILITIES | 10218504 | | | 43 |
| CAPITAL ACCOUNTS | | | | | |
| 44 | GENERAL FUND BALANCE | 21429554 | | | 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 | 21429554 | | | 51 |
| 52 | TOTAL LIABILITIES AND FUND BALANCES | 31648058 | | | 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 | 20104214 | | | 1 |
| 2 NET INCOME (LOSS) | 1325340 | | | 2 |
| 3 TOTAL | 21429554 | | | 3 |
| 4 ADDITIONS (CREDIT ADJUSTMENTS) | | | | 4 |
| 5 | | | | 5 |
| 6 | | | | 6 |
| 7 | | | | 7 |
| 8 | | | | 8 |
| 9 | | | | 9 |
| 10 TOTAL ADDITIONS | | | | 10 |
| 11 SUBTOTAL | 21429554 | | | 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 | 21429554 | | | 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 HOSPITAL | 2614289 | | 2614289 | 1 |
| 2 SUBPROVIDER I | | | | 2 |
| 4 SWING BED - SNF | 26980 | | 26980 | 4 |
| 5 SWING BED - NF | | | | 5 |
| 6 SKILLED NURSING FACILITY | | | | 6 |
| 7 NURSING FACILITY | | | | 7 |
| 8 OTHER LONG TERM CARE | | | | 8 |
| 9 TOTAL GENERAL INPATIENT CARE SERVICES | 2641269 | | 2641269 | 9 |
| 10 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES | | | | |
| 10 INTENSIVE CARE UNIT | 259875 | | 259875 | 10 |
| 11 CORONARY CARE UNIT | | | | 11 |
| 12 BURN INTENSIVE CARE UNIT | | | | 12 |
| 13 SURGICAL INTENSIVE CARE UNIT | | | | 13 |
| 14 OTHER SPECIAL CARE (SPECIFY) | | | | 14 |
| 15 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE | 259875 | | 259875 | 15 |
| 16 TOTAL INPATIENT ROUTINE CARE SERVICES | 2901144 | | 2901144 | 16 |
| 17 ANCILLARY SERVICES | 7389865 | | 7389865 | 17 |
| 18 OUTPATIENT SERVICES | | 37571748 | 37571748 | 18 |
| 18.50 PHOTOS RHC | | 341836 | 341836 | 18.50 |
| 18.60 FQHC | | | | 18.60 |
| 19 HOME HEALTH AGENCY | | | | 19 |
| 20 AMBULANCE | | | | 20 |
| 21 CORP | | | | 21 |
| 22 ASC | | | | 22 |
| 23 HOSPICE | | | | 23 |
| 24 | | | | 24 |
| 25 TOTAL PATIENT REVENUES | 10291009 | 37913584 | 48204593 | 25 |

PART II - OPERATING EXPENSES

| | 1 | 2 | |
|-----------------------------|---|----------|----|
| 26 OPERATING EXPENSES | | 23452057 | 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 | | 23452057 | 40 |

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

| DESCRIPTION | | | |
|-------------|---|----------|-------|
| 1 | TOTAL PATIENT REVENUES | 48204593 | 1 |
| 2 | LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS | 24038806 | 2 |
| 3 | NET PATIENT REVENUES | 24165787 | 3 |
| 4 | LESS - TOTAL OPERATING EXPENSES | 23452057 | 4 |
| 5 | NET INCOME FROM SERVICE TO PATIENTS | 713730 | 5 |
| 6 | CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC. | | 6 |
| 7 | INCOME FROM INVESTMENTS | 22346 | 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 | 137524 | 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 | 3 | 18 |
| 19 | TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.) | | 19 |
| 20 | REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN | 55370 | 20 |
| 21 | RENTAL OF VENDING MACHINES | | 21 |
| 22 | RENTAL OF HOSPITAL SPACE | | 22 |
| 23 | GOVERNMENTAL APPROPRIATIONS | | 23 |
| 24 | PROPERTY TAX REVENUE | 215157 | 24 |
| 24.01 | OTHER OPERATING INCOME (EXPENSE) | 57706 | 24.01 |
| 24.02 | LOSS ON DISPOSITION OF EQUIPMENT | -26460 | 24.02 |
| 24.03 | NONCAPITAL GRANTS AND CONTRIBUTIONS | 149964 | 24.03 |
| 24.04 | TRANSFER OF FOUNDATION ASSETS | | 24.04 |
| 25 | TOTAL OTHER INCOME | 611610 | 25 |
| 26 | TOTAL | 1325340 | 26 |
| 27 | | | 27 |
| 28 | | | 28 |
| 29 | | | 29 |
| 30 | TOTAL OTHER EXPENSES | | 30 |
| 31 | NET INCOME (OR LOSS) FOR THE PERIOD | 1325340 | 31 |

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 TEMPORARILY 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 | 88573 | 6271 | 94844 | | 94844 | | 94844 | 2 |
| 3 NURSE PRACTITIONER | | | | | | | | 3 |
| 4 VISITING NURSE | | | | | | | | 4 |
| 5 OTHER NURSE | 115426 | 8172 | 123598 | | 123598 | | 123598 | 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) | 203999 | 14443 | 218442 | | 218442 | | 218442 | 10 |
| COSTS UNDER AGREEMENT | | | | | | | | |
| 11 PHYSICIAN SERVICES UNDER AGREEMENT | | 335972 | 335972 | 34080 | 370052 | | 370052 | 11 |
| 12 PHYSICIAN SUPERVISION UNDER AGREEMENT | | | | | | | | 12 |
| 13 OTHER COSTS UNDER AGREEMENT | | | | | | | | 13 |
| 14 SUBTOTAL (SUM OF LINES 11-13) | | 335972 | 335972 | 34080 | 370052 | | 370052 | 14 |
| OTHER HEALTH CARE COSTS | | | | | | | | |
| 15 MEDICAL SUPPLIES | | 5869 | 5869 | | 5869 | | 5869 | 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) | | 5869 | 5869 | | 5869 | | 5869 | 21 |
| 22 TOTAL COSTS OF HEALTH CARE SERVICES | 203999 | 356284 | 560283 | 34080 | 594363 | | 594363 | 22 |
| COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | | | |
| 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 | 59239 | 4895 | 64134 | | 64134 | | 64134 | 30 |
| 31 TOTAL FACILITY OVERHEAD | 59239 | 4895 | 64134 | | 64134 | | 64134 | 31 |
| 32 TOTAL FACILITY COSTS | 263238 | 361179 | 624417 | 34080 | 658497 | | 658497 | 32 |

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

RHC I
 COMPONENT NO: 14-3413

WORKSHEET M-2

CHECK [XX] RHC
 APPLICABLE BOX: [] FQHC

VISITS AND PRODUCTIVITY

| | NUMBER OF FTE PERSONNEL 1 | TOTAL VISITS 2 | PRODUCTIVITY STANDARD 3 | MINIMUM VISITS 4 | GREATER OF COL. 2 OR COL. 4 5 | |
|---------------------------------------|------------------------------------|----------------------|-------------------------------|------------------------|--|---|
| 1 PHYSICIANS | | | 4200 | | | 1 |
| 2 PHYSICIAN ASSISTANTS | 1.05 | 1792 | 2100 | 2205 | | 2 |
| 3 NURSE PRACTITIONERS | | | 2100 | | | 3 |
| 4 SUBTOTAL | 1.05 | 1792 | | 2205 | 2205 | 4 |
| 5 VISITING NURSE | | | | | | 5 |
| 6 CLINICAL PSYCHOLOGIST | | | | | | 6 |
| 7 CLINICAL SOCIAL WORKER | | | | | | 7 |
| 8 TOTAL FTEs AND VISITS | 1.05 | 1792 | | | 2205 | 8 |
| 9 PHYSICIAN SERVICES UNDER AGREEMENTS | | 1456 | | | 1456 | 9 |

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

| | | | | | | |
|---|--|--|--|--|----------|----|
| 10 TOTAL COSTS OF HEALTH CARE SERVICES | | | | | 594363 | 10 |
| 11 TOTAL NONREIMBURSABLE COSTS | | | | | | 11 |
| 12 COST OF ALL SERVICES (EXCLUDING OVERHEAD) | | | | | 594363 | 12 |
| 13 RATIO OF RHC/FQHC SERVICES | | | | | 1.000000 | 13 |
| 14 TOTAL FACILITY OVERHEAD | | | | | 64134 | 14 |
| 15 PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY | | | | | 208790 | 15 |
| 16 TOTAL OVERHEAD | | | | | 272924 | 16 |
| 17 ALLOWABLE GME OVERHEAD | | | | | | 17 |
| 18 SUBTRACT LINE 17 FROM LINE 16 | | | | | 272924 | 18 |
| 19 OVERHEAD APPLICABLE TO RHC/FQHC SERVICES | | | | | 272924 | 19 |
| 20 TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES | | | | | 867287 | 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 | 867287 | 1 |
| 2 | COST OF VACCINES AND THEIR ADMINISTRATION | 10261 | 2 |
| 3 | TOTAL ALLOWABLE COST EXCLUDING VACCINE | 857026 | 3 |
| 4 | TOTAL VISITS | 2205 | 4 |
| 5 | PHYSICIANS VISITS UNDER AGREEMENT | 1456 | 5 |
| 6 | TOTAL ADJUSTED VISITS | 3661 | 6 |
| 7 | ADJUSTED COST PER VISIT | 234.10 | 7 |

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

| | | | | |
|---|---------------------------------|--------|--------|---|
| 8 | PER VISIT PAYMENT LIMIT | 193.29 | 159.38 | 8 |
| 9 | RATE FOR PROGRAM COVERED VISITS | 234.10 | 234.10 | 9 |

CALCULATION OF SETTLEMENT

| | | | | |
|-------|--|-------|-------|----------|
| 10 | PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES | 184 | 184 | 10 |
| 11 | PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES | 43074 | 43074 | 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 | | | 86148 16 |
| 16.01 | PRIMARY PAYOR PAYMENTS | | | 16.01 |
| 17 | LESS: BENEFICIARY DEDUCTIBLE | | | 7412 17 |
| 18 | NET PROGRAM COST EXCLUDING VACCINES | | | 78736 18 |
| 19 | REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE | | | 62989 19 |
| 20 | PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION | | | 10261 20 |
| 21 | TOTAL REIMBURSABLE PROGRAM COST | | | 73250 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 | | | 73250 24 |
| 25 | INTERIM PAYMENTS | | | 45315 25 |
| 25.01 | TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY) | | | 25.01 |
| 26 | BALANCE DUE COMPONENT/PROGRAM | | | 27935 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 | 218442 | 218442 | 218442 | 218442 | 1 |
| 2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME | 0.008397 | 0.008397 | | | 2 |
| 3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST | 1834 | 1834 | | | 3 |
| 4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE | 733 | 2631 | | | 4 |
| 5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE | 2567 | 4465 | | | 5 |
| 6 TOTAL DIRECT COST OF THE FACILITY | 594363 | 594363 | 594363 | 594363 | 6 |
| 7 TOTAL OVERHEAD | 272924 | 272924 | 272924 | 272924 | 7 |
| 8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DRECT COST | 0.004319 | 0.007512 | | | 8 |
| 9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE | 1179 | 2050 | | | 9 |
| 10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COST AND ITS (THEIR) ADMINISTRATION | 3746 | 6515 | | | 10 |
| 11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS | 14 | 216 | | | 11 |
| 12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION | 267.57 | 30.16 | | | 12 |
| 13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO MEDICARE BENEFICIARIES | 14 | 216 | | | 13 |
| 14 MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | 3746 | 6515 | | | 14 |
| 15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | | 10261 | | | 15 |
| 16 TOTAL MEDICARE COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE AND ITS (THEIR) ADMINISTRATION | | 10261 | | | 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 | | AMOUNT | |
|--|-----------------|---|----------------------------|------|
| | 1 MM/DD/YYYY | 2 | | |
| 1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER | | | 43300 | 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. | .01 10/31/2010 | | 2015 | 3.01 |
| PROGRAM | .02 | | | 3.02 |
| TO | .03 | | | 3.03 |
| PROVIDER | .04 | | | 3.04 |
| | .05 | | | 3.05 |
| | .50 | | | 3.50 |
| PROVIDER | .51 | | | 3.51 |
| TO | .52 | | NONE | 3.52 |
| PROGRAM | .53 | | | 3.53 |
| | .54 | | | 3.54 |
| SUBTOTAL | .99 | | 2015 | 3.99 |
| 4 TOTAL INTERIM PAYMENTS | | | 45315 | 4 |
| TO BE COMPLETED BY INTERMEDIARY | | | | |
| 5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. | PROGRAM .01 | | | 5.01 |
| | TO .02 | | NONE | 5.02 |
| | PROVIDER .03 | | | 5.03 |
| | PROVIDER .50 | | | 5.50 |
| | TO .51 | | NONE | 5.51 |
| | PROGRAM .52 | | | 5.52 |
| SUBTOTAL | .99 | | | 5.99 |
| 6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT. | PROGRAM TO .01 | | 27935 | 6.01 |
| | PROVIDER TO .02 | | | 6.02 |
| | PROGRAM | | | |
| 7 TOTAL MEDICARE PROGRAM LIABILITY | | | 73250 | 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 | 74.18 | | 6.44 | | | | 80.62 25 |
| UTILIZATION PERCENTAGES BASED ON CHARGES | | | | | | | |
| 37 OPERATING ROOM | 7.59 | 46.09 | 2.96 | | | | 56.64 37 |
| 41 RADIOLOGY-DIAGNOSTIC | 6.73 | 36.95 | 1.41 | | | | 45.09 41 |
| 44 LABORATORY | 12.53 | 33.16 | 1.46 | | | | 47.15 44 |
| 49 RESPIRATORY THERAPY | 14.53 | 18.10 | 1.95 | | | | 34.58 49 |
| 50 PHYSICAL THERAPY | 6.17 | 35.41 | 0.11 | | | | 41.69 50 |
| 53 ELECTROCARDIOLOGY | 8.46 | 62.65 | 1.26 | | | | 72.37 53 |
| 55 MEDICAL SUPPLIES CHARGED TO PAT | 47.78 | 37.88 | 3.32 | | | | 88.98 55 |
| 56 DRUGS CHARGED TO PATIENTS | 34.63 | 36.03 | 3.37 | | | | 74.03 56 |
| 60 CLINIC | 0.01 | 49.59 | 0.19 | | | | 49.79 60 |
| 61 EMERGENCY | 0.12 | 36.14 | 1.52 | | | | 37.78 61 |
| 62 OBSERVATION BEDS (NON-DISTINCT | | 64.49 | | | | | 64.49 62 |
| 101 TOTAL CHARGES | 10.85 | 33.34 | 1.57 | | | | 45.76 101 |

| COST CENTER | --- DIRECT COSTS --- | | -- ALLOCATED OVERHEAD -- | | --- TOTAL COSTS --- | | |
|-------------------------------------|----------------------|------|--------------------------|--------|---------------------|-------|-------|
| | AMOUNT | % | AMOUNT | % | AMOUNT | % | |
| GENERAL SERVICE COST CENTERS | | | | | | | |
| 1 | | | | | | | 1 |
| 2 | | | | | | | 2 |
| 3 | 1042135 | 5.26 | -1042135 | -10.63 | | | 3 |
| 4 | 1436258 | 7.25 | -1436258 | -14.65 | | | 4 |
| 5 | 1616436 | 8.16 | -1616436 | -16.49 | | | 5 |
| 6.01 | 1269747 | 6.41 | -1269747 | -12.95 | | | 6.01 |
| 6.02 | 978051 | 4.94 | -978051 | -9.98 | | | 6.02 |
| 7 | | | | | | | 7 |
| 8 | 968277 | 4.89 | -968277 | -9.88 | | | 8 |
| 9 | 55775 | .28 | -55775 | -.57 | | | 9 |
| 10 | 223592 | 1.13 | -223592 | -2.28 | | | 10 |
| 11 | 128572 | .65 | -128572 | -1.31 | | | 11 |
| 12 | 352354 | 1.78 | -352354 | -3.59 | | | 12 |
| 13 | | | | | | | 13 |
| 14 | 69598 | .35 | -69598 | -.71 | | | 14 |
| 15 | | | | | | | 15 |
| 15.01 | 90425 | .46 | -90425 | -.92 | | | 15.01 |
| 15.02 | | | | | | | 15.02 |
| 16 | 1121399 | 5.66 | -1121399 | -11.44 | | | 16 |
| 17 | 398567 | 2.01 | -398567 | -4.07 | | | 17 |
| 18 | 51714 | .26 | -51714 | -.53 | | | 18 |
| 20 | | | | | | | 20 |
| 21 | | | | | | | 21 |
| 22 | | | | | | | 22 |
| 23 | | | | | | | 23 |
| 24 | | | | | | | 24 |
| INPATIENT ROUTINE SERV COST CENTERS | | | | | | | |
| 25 | 1767098 | 8.92 | 1877693 | 19.15 | 3644791 | 18.40 | 25 |
| 26 | | | | | | | 26 |
| ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 37 | 872814 | 4.41 | 980746 | 10.00 | 1853560 | 9.36 | 37 |
| 40 | | | | | | | 40 |
| 41 | 1311085 | 6.62 | 1793155 | 18.29 | 3104240 | 15.67 | 41 |
| 44 | 1499787 | 7.57 | 1207249 | 12.32 | 2707036 | 13.66 | 44 |
| 46.30 | | | | | | | 46.30 |
| 49 | 441129 | 2.23 | 398638 | 4.07 | 839767 | 4.24 | 49 |
| 50 | 825309 | 4.17 | 404835 | 4.13 | 1230144 | 6.21 | 50 |
| 51 | | | | | | | 51 |
| 52 | | | | | | | 52 |
| 53 | 62953 | .32 | 62379 | .64 | 125332 | .63 | 53 |
| 55 | 608311 | 3.07 | 160355 | 1.64 | 768666 | 3.88 | 55 |
| 56 | | | 1364955 | 13.92 | 1364955 | 6.89 | 56 |
| 60 | 149287 | .75 | 87456 | .89 | 236743 | 1.19 | 60 |
| 60.01 | | | | | | | 60.01 |
| 61 | 1673496 | 8.45 | 816731 | 8.33 | 2490227 | 12.57 | 61 |
| 62 | | | | | | | 62 |

| COST CENTER | --- DIRECT COSTS --- | | -- ALLOCATED OVERHEAD -- | | --- TOTAL COSTS --- | | |
|---------------------------------------|----------------------|--------|--------------------------|------|---------------------|--------|-------|
| | AMOUNT | % | AMOUNT | % | AMOUNT | % | |
| 63.50 PHOTOS RHC | 658497 | 3.32 | 208790 | 2.13 | 867287 | 4.38 | 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 | | | | | | | 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 | 99824 | .50 | 69569 | .71 | 169393 | .86 | 96 |
| 98 PHYSICIANS' PRIVATE OFFICES | 38978 | .20 | 141905 | 1.45 | 180883 | .91 | 98 |
| 98.01 TEMPORARILY IDLE SPACE | | | 228444 | 2.33 | 228444 | 1.15 | 98.01 |
| 101 CROSS FOOT ADJUSTMENTS | | | | | | | 101 |
| 102 NEGATIVE COST CENTER | | | | | | | 102 |
| 103 TOTAL | 19811468 | 100.00 | 0 | .00 | 19811468 | 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 OPPTS. (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) | 5032436 |
| 2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (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) | 14395374 |
| 3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2) | .350 |

ELECTRONIC FILE NAME: C:\255296WL\CMTEMP\EC141345.11A

WIN-LASH FILE NAME: C:\255296WL\CMTEMP\CRECTEMP

PROVIDER NUMBER: 14-1345

SOFTWARE VENDOR: T01
KPMG LLP - COMPU-MAX MICRO - DATE APPROVED: 02/19/10

CREATION DATE: 8/2/2011

CREATION TIME: 08:24

PROVIDER NAME: SALEM TOWNSHIP HOSPITAL

FISCAL YEAR BEGINNING: 04/01/2010

FISCAL YEAR ENDING: 03/31/2011

ECR FINGERPRINT:

REMARKS:

 ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT

CMS REQUIRED EDITS ARE APPLIED AT TWO LEVELS:

LEVEL I EDITS ARE THOSE WHICH TEST THE FORMAT OF THE DATA TO IDENTIFY FOR CORRECTION THOSE ERROR CONDITIONS WHICH MAY RESULT IN A COST REPORT REJECTION. INTERMEDIARIES MAY REJECT ALL ELECTRONIC COST REPORTING FILES WHICH CONTAIN ONE OR MORE LEVEL I EDIT ERRORS. LEVEL I EDITS ARE IDENTIFIED WITH NUMBERS BETWEEN 1000 AND 1999.

LEVEL II EDITS IDENTIFY POTENTIAL INCONSISTENCIES AND/OR MISSING DATA ITEMS. THESE ITEMS SHOULD BE RESOLVED AT THE PROVIDER SITE AND APPROPRIATE WORKSHEETS AND/OR DATA SUBMITTED WITH THE COST REPORT. FAILURE TO SUBMIT THE APPROPRIATE DATA WITH YOUR COST REPORT MAY RESULT IN PAYMENTS BEING WITHHELD PENDING RESOLUTION OF THE ISSUE(S). LEVEL II EDITS ARE IDENTIFIED WITH NUMBERS BETWEEN 2000 AND 2999.

WORKSHEET A COST CENTER LIST: (THE ASTERISK INDICATES THAT THERE IS NO DIRECT INPUT DATA ASSOCIATED WITH THE COST CENTER)

| CMS EDIT NO. | | | |
|--------------|--------------------------------------|------|----|
| 1 | OLD CAP REL COSTS-BLDG & FIXT | 0100 | ** |
| 2 | OLD CAP REL COSTS-MVBLE EQUIP | 0200 | ** |
| 3 | NEW CAP REL COSTS-BLDG & FIXT | 0300 | |
| 4 | NEW CAP REL COSTS-MVBLE EQUIP | 0400 | |
| 5 | EMPLOYEE BENEFITS | 0500 | |
| 6 1 | ADMINISTRATIVE & ACCOUNTING | 0662 | |
| 6 2 | BUSINESS SERVICES | 0661 | |
| 7 | MAINTENANCE & REPAIRS | 0700 | ** |
| 8 | OPERATION OF PLANT | 0800 | |
| 9 | LAUNDRY & LINEN SERVICE | 0900 | |
| 10 | HOUSEKEEPING | 1000 | |
| 11 | DIETARY | 1100 | |
| 12 | CAFETERIA | 1200 | |
| 13 | MAINTENANCE OF PERSONNEL | 1300 | ** |
| 14 | NURSING ADMINISTRATION | 1400 | |
| 15 | CENTRAL SERVICES & SUPPLY | 1500 | ** |
| 15 1 | PURCHASING | 1501 | |
| 15 2 | CENTRAL SERVICES & SUPPLY | 1502 | |
| 16 | PHARMACY | 1600 | |
| 17 | MEDICAL RECORDS & LIBRARY | 1700 | |
| 18 | SOCIAL SERVICE | 1800 | |
| 20 | NONPHYSICIAN ANESTHETISTS | 2000 | |
| 21 | NURSING SCHOOL | 2100 | ** |
| 22 | I&R SERVICES-SALARY & FRINGES APPRVD | 2200 | ** |
| 23 | I&R SERVICES-OTHER PRGM COSTS APPRVD | 2300 | ** |
| 24 | PARAMED ED PRGM-(SPECIFY) | 2400 | ** |
| 25 | ADULTS & PEDIATRICS | 2500 | |
| 26 | INTENSIVE CARE UNIT | 2600 | ** |
| 37 | OPERATING ROOM | 3700 | |
| 40 | ANESTHESIOLOGY | 4000 | |
| 41 | RADIOLOGY-DIAGNOSTIC | 4100 | |
| 44 | LABORATORY | 4400 | |
| 4630 | BLOOD CLOTTING FACTORS ADMIN COSTS | 4650 | ** |
| 49 | RESPIRATORY THERAPY | 4900 | |

ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT (CONTINUED)

CMS
EDIT NO.

| | | | |
|------|--------------------------------------|------|----|
| 50 | PHYSICAL THERAPY | 5000 | |
| 51 | OCCUPATIONAL THERAPY | 5100 | ** |
| 52 | SPEECH PATHOLOGY | 5200 | ** |
| 53 | ELECTROCARDIOLOGY | 5300 | |
| 55 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 5500 | |
| 56 | DRUGS CHARGED TO PATIENTS | 5600 | |
| 60 | CLINIC | 6000 | |
| 60 1 | SALEM MEDICAL CLINIC | 6001 | ** |
| 61 | EMERGENCY | 6100 | |
| 62 | OBSERVATION BEDS (NON-DISTINCT PART) | 6200 | |
| 6350 | PHOTOS RHC | 6310 | |
| 6360 | FQHC | 6320 | ** |
| 6910 | CMHC | 6910 | ** |
| 6920 | OUTPATIENT PHYSICAL THERAPY | 6920 | ** |
| 6930 | OUTPATIENT OCCUPATIONAL THERAPY | 6930 | ** |
| 6940 | OUTPATIENT SPEECH PATHOLOGY | 6940 | ** |
| 71 | HOME HEALTH AGENCY | 7100 | ** |
| 85 1 | PANCREAS ACQUISITION | 8510 | ** |
| 85 2 | INTESTINAL ACQUISITION | 8520 | ** |
| 85 3 | ISLET CELL ACQUISITION | 8530 | ** |
| 96 | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 9600 | |
| 98 | PHYSICIANS' PRIVATE OFFICES | 9800 | |
| 98 1 | TEMPORARILY IDLE SPACE | 9801 | |

PROVIDER NO. 14-1345 SALEM TOWNSHIP HOSPITAL
PERIOD FROM 04/01/2010 TO 03/31/2011

RUN DATE: 08/02/2011

ELECTRONIC REPORTING FILE VALIDATION AND EDIT REPORT (CONTINUED)

CMS
EDIT NO.

2145S WORKSHEET S-4, COL 1 OR COL 1.01, LINE 19 MUST BE GREATER THAN ZERO AND
THE NUMBER OF MSA OR CBSA CODES ON LINE 20 AND SUBSCRIPTS MUST EQUAL
THE NUMBER IDENTIFIED ON LINE 19 FOR HHA I

WORKSHEET E-1 - INTERIM PAYMENT SUMMARY

| | PART A | PART B | TOTAL |
|------------------------|---------|---------|---------|
| 1 HOSPITAL | 3642042 | 3537276 | 7179318 |
| 2 SUBPROVIDER I | | | |
| 3 SWING-BED SNF | 142495 | | 142495 |
| 4 SKILLED NURSING FAC | | | |
| 5 HOME HEALTH AGENCY I | | | |
| 6 CORF | | | |
| TOTAL | 3784537 | 3537276 | 7321813 |

WORKSHEET S - SETTLEMENT SUMMARY

| | TITLE V | TITLE XVIII PART A | TITLE XVIII PART B | TITLE XIX | |
|-----|--------------------------|--------------------------|--------------------------|--------------|-----|
| | 1 | 2 | 3 | 4 | |
| 1 | HOSPITAL | 405167 | 196742 | 495621 | 1 |
| 2 | SUBPROVIDER I | | | | 2 |
| 3 | SWING BED - SNF | 15713 | | | 3 |
| 4 | SWING BED - NF | | | | 4 |
| 5 | SKILLED NURSING FACILITY | | | | 5 |
| 6 | NURSING FACILITY | | | | 6 |
| 7 | HOME HEALTH AGENCY | | | | 7 |
| 8 | CORF | | | | 8 |
| 9 | RHC | | 27935 | | 9 |
| 100 | TOTAL | 420880 | 224677 | 495621 | 100 |