

SALEM TOWNSHIP HOSPITAL

SALEM, ILLINOIS

MEDICARE ANALYSIS

FOR THE YEAR ENDED MARCH 31, 2012

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

WORKSHEET S  
 PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY 1.  ELECTRONICALLY FILED COST REPORT DATE: 08/27/2012 TIME: 15:18  
 2.  MANUALLY SUBMITTED COST REPORT  
 3.  IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THIS COST REPORT  
 4.  MEDICARE UTILIZATION. ENTER "F" FOR FULL OR "L" FOR LOW.

CONTRACTOR USE ONLY 5.  COST REPORT STATUS 6. DATE RECEIVED: \_\_\_\_\_ 10. NPR DATE: \_\_\_\_\_  
 1 - AS SUBMITTED 7. CONTRACTOR NO: \_\_\_\_\_ 11. CONTRACTOR'S VENDOR CODE: \_\_\_\_\_  
 2 - SETTLED WITHOUT AUDIT 8.  INITIAL REPORT FOR THIS PROVIDER CCN 12.  IF LINE 5, COLUMN 1 IS 4: ENTER  
 3 - SETTLED WITH AUDIT 9.  FINAL REPORT FOR THIS PROVIDER CCN NUMBER OF TIMES REOPENED - 0-9.  
 4 - REOPENED  
 5 - AMENDED

PART II - CERTIFICATION

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 04/01/2011 AND ENDING 03/31/2012, AND 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 IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 08/27/2012 15:18  
 :VG5hL9uTUx1hnMgTQofOqGKBALHh0  
 goVG10yggQER3NDqQ4aQv8qNwxgSlG8  
 moZE0jqYl80Wrrr0

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

\_\_\_\_\_  
 TITLE

\_\_\_\_\_  
 DATE

PI Encryption: 08/27/2012 15:18  
 Syq14V77Wve8fXWlRavchW.04ID7i0  
 LR76l07fTc2sW61dnkKol2RaJQkuqi  
 GkRg0qvw1e0v6bDd

PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII PART A 2	PART B 3	HIT 4	TITLE XIX 5	
1	HOSPITAL	-116,759	291,538	13,804	150,857	1
2	SUBPROVIDER - IPF					2
3	SUBPROVIDER - IRF					3
4	SUBPROVIDER (OTHER)					4
5	SWING BED - SNF	6,836				5
6	SWING BED - NF					6
7	SKILLED NURSING FACILITY					7
8	NURSING FACILITY					8
9	HOME HEALTH AGENCY					9
10	HEALTH CLINIC - RHC		-18,568			10
11	HEALTH CLINIC - FQHC					11
12	OUTPATIENT REHABILITATION PROVIDER					12
200	TOTAL	-109,923	272,970	13,804	150,857	200

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 673 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: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 1201 RICKER DRIVE  
 2 CITY: SALEM

STATE: IL

P.O.BOX:  
 ZIP CODE: 62881

COUNTY: MARION

1  
 2

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	CCN NUMBER 2	CBSA NUMBER 3	PROV TYPE 4	DATE CERTIFIED 5	PAYMENT SYSTEM (P, T, O, OR N)			
						V 6	XVIII 7	XIX 8	
3	HOSPITAL	14-1345	16460	1	07/01/1966	N	O	O	3
4	SUBPROVIDER - IPF								4
5	SUBPROVIDER - IRF								5
6	SUBPROVIDER - (OTHER)								6
7	SWING BEDS - SNF	14-2345	16460		12/17/1986	N	O	N	7
8	SWING BEDS - NF								8
9	HOSPITAL-BASED SNF								9
10	HOSPITAL-BASED NF								10
11	HOSPITAL-BASED OLTG								11
12	HOSPITAL-BASED HHA	14-7429	16460		08/01/1985	N	P	N	12
13	SEPARATELY CERTIFIED ASC								13
14	HOSPITAL-BASED HOSPICE								14
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-3413	16460		07/29/1996	N	O	N	15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC								16
17	HOSPITAL-BASED (CMHC)								17
18	RENAL DIALYSIS								18
19	OTHER								19
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 04/01/2011			TO: 03/31/2012				20
21	TYPE OF CONTROL				12				21

INPATIENT PPS INFORMATION

		IN-STATE MEDICAID PAID DAYS 1	IN-STATE MEDICAID ELIGIBLE DAYS 2	OUT-OF- STATE MEDICAID PAID DAYS 3	OUT-OF- STATE MEDICAID ELIGIBLE DAYS 4	MEDICAID HMO DAYS 5	OTHER MEDICAID DAYS 6	
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR §412.06(c)(2) (PICKLE AMENDMENT HOSPITAL)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.							N N 22
23	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON LINES 24 AND/OR 25 BELOW? IN COLUMN 1, ENTER 1 IF DATE OF ADMISSION, 2 IF CENSUS DAYS, OR 3 IF DATE OF DISCHARGE. IS THE METHOD OF IDENTIFYING THE DAYS IN THIS COST REPORTING PERIOD DIFFERENT FROM THE METHOD USED IN THE PRIOR COST REPORTING PERIOD? IN COLUMN 2, ENTER 'Y' FOR YES OR 'N' FOR NO.							3 N 23
24	IF LINE 22 AND/OR 45 IS 'YES', AND THIS PROVIDER IS AN IPPS HOSPITAL ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							24
25	IF THIS PROVIDER IS AN IRF THEN, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE DAYS IN COL. 2, OUT-OF STATE MEDICAID DAYS IN COL. 3, OUT-OF STATE MEDICAID ELIGIBLE DAYS IN COL. 4, MEDICAID HMO DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.							25
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.				2			26
27	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE) STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL. IF APPLICABLE, ENTER THE EFFECTIVE DATE OF THE GEOGRAPHIC RECLASSIFICATION IN COLUMN 2.				2			27
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							35
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		36
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.							37
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:		ENDING:		38

PROSPECTIVE PAYMENT SYSTEM(PPS)-CAPITAL

		V 1	XVIII 2	XIX 3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	N	N	45
46	IS THIS FACILITY ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR §412.348(g)? IF YES, COMPLETE WORKSHEET L, PART III AND L-1, PARTS I THROUGH III.	N	N	N	46
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

TEACHING HOSPITALS

	1	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		56
57	IF LINE 56 IS YES, IS THIS THE FIRST COST REPORTING PERIOD DURING WHICH RESIDENTS IN APPROVED GME PROGRAMS TRAINED AT THIS FACILITY? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y' DID RESIDENTS START TRAINING IN THE FIRST MONTH OF THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2. IF COLUMN 2 IS 'Y', COMPLETE WORKSHEET E-4. IF COLUMN 2 IS 'N', COMPLETE WORKSHEET D, PART III & IV AND D-2, PART II, IF APPLICABLE.	N	N	57
58	IF LINE 56 IS YES, DID THIS FACILITY ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-5.	N		58
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N		59
60	ARE YOU CLAIMING NURSING SCHOOL AND/OR ALLIED HEALTH COSTS FOR A PROGRAM THAT MEETS THE PROVIDER-OPERATED CRITERIA UNDER §413.85? ENTER 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N		60

	Y/N	IME AVERAGE	DIRECT GME AVERAGE	
61	DID YOUR FACILITY RECEIVE ADDITIONAL FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF 'Y', EFFECTIVE FOR PORTIONS OF COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2011 ENTER THE AVERAGE NUMBER OF PRIMARY CARE FTE RESIDENTS FOR IME IN COLUMN 2 AND DIRECT GME IN COLUMN 3 FROM THE HOSPITAL'S THREE MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (SEE INSTRUCTIONS)	N		61

ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)

62	ENTER THE NUMBER OF FTE RESIDENTS THAT YOUR HOSPITAL TRAINED IN THIS COST REPORTING PERIOD FOR WHICH YOUR HOSPITAL RECEIVED HRSA PCRE FUNDING (SEE INSTRUCTIONS)			62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (SEE INSTRUCTIONS)			62.01

TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS

63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (SEE INSTRUCTIONS)	N		63
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SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
64	THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010. ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			64

ENTER IN LINES 65-65.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2  
 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY  
 CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-  
 PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY  
 CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5  
 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 + COLUMN 4)). (SEE  
 INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5

SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS

	UNWEIGHTED FTES NONPROVIDER SITE	UNWEIGHTED FTES IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	
66	EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010 ENTER IN COLUMN 1, THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 2 THE NUMBER OF UNWEIGHTED NON-PRIMARY CARE RESIDENT FTES THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 3 THE RATIO OF (COLUMN 1 DIVIDED BY (COLUMN 1 + COLUMN 2)). (SEE INSTRUCTIONS)			66

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

ENTER IN LINES 67-67.49, COLUMN 1 THE PROGRAM NAME. ENTER IN COLUMN 2 THE PROGRAM CODE. ENTER IN COLUMN 3 THE NUMBER OF UNWEIGHTED PRIMARY CARE FTE RESIDENTS ATTRIBUTABLE TO ROTATIONS OCCURRING IN ALL NON-PROVIDER SETTINGS. ENTER IN COLUMN 4 THE NUMBER OF UNWEIGHTED PRIMARY CARE RESIDENT FTEs THAT TRAINED IN YOUR HOSPITAL. ENTER IN COLUMN 5 THE RATIO OF COLUMN 3 DIVIDED BY (COLUMN 3 ÷ COLUMN 4). (SEE INSTRUCTIONS)

PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.3+COL.4))
1	2	3	4	5
<b>INPATIENT PSYCHIATRIC FACILITY PPS</b>				
70	IS THIS FACILITY AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DOES IT CONTAIN AN IPF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 70
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			71
<b>INPATIENT REHABILITATION FACILITY PPS</b>				
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 75
76	IF LINE 75 YES: COLUMN 1: DID 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. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. IF THIS COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH YEAR, ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5.			76
<b>LONG TERM CARE HOSPITAL PPS</b>				
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80
<b>TEFRA PROVIDERS</b>				
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 85
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.			N 86
<b>TITLE V AND XIX INPATIENT SERVICES</b>				
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			V 1 XIX 2 N Y 90
91	IS THIS HOSPITAL REIMBURSED FOR TITLE V AND/OR XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? ENTER 'Y' FOR YES, OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 91
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N 92
93	DOES THIS FACILITY OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE V AND XIX? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 93
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 94
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			N N 96
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97
<b>RURAL PROVIDERS</b>				
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			1 2 Y 105
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			N 106
107	COLUMN 1: 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 IN COLUMN 1. 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, COLUMN 2: IF THIS FACILITY IS A CAH, DO I&RS IN AN APPROVED MEDICAL EDUCATION PROGRAM TRAIN IN THE CAH'S EXCLUDED IPF AND/OR IRF UNIT? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 2.			N N 107
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.			N 108
109	IF THIS HOSPITAL QUALIFIES AS A CAH OR A COST PROVIDER, ARE THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIER? ENTER 'Y' FOR YES OR 'N' FOR EACH THERAPY.			PHY- OCCUP- RESPI- SICAL ATIONAL SPEECH RATORY Y Y Y N 109

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 PART I (CONT)

MISCELLANEOUS COST REPORTING INFORMATION

115	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.	N	2	115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		117
118	IS THE MALPRACTICE INSURANCE A CLAIMS-MADE OR OCCURRENCE POLICY? ENTER 1 IF THE POLICY IS CLAIM-MADE. ENTER 2 IF THE POLICY IS OCCURRENCE.	1		118
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: 144,603 PAID LOSSES: AND/OR SELF INSURANCE:			118.01
118.02	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.	N		118.02
120	IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? AS AMENDED BY THE MEDICAID EXTENDER ACT (MMEA) §108? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.	N	N	120
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		121

TRANSPLANT CENTER INFORMATION

125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S) (MM/DD/YYYY) BELOW.	N		125
126	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			126
127	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			127
128	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			128
129	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			129
130	IF THIS IS A MEDICARE CERTIFIED PANCREAS TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			130
131	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			131
132	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			132
133	IF THIS IS A MEDICARE CERTIFIED OTHER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			133
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.			134

ALL PROVIDERS

140	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-1, CHAPTER 10? ENTER 'Y' FOR YES, OR 'N' FOR NO IN COLUMN 1. IF YES, AND HOME OFFICE COSTS ARE CLAIMED, ENTER IN COLUMN 2 THE HOME OFFICE CHAIN NUMBER.	N	2	140
-----	--	---	---	-----

IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER ON LINES 141 THROUGH 143 THE NAME AND ADDRESS OF THE HOME OFFICE AND ENTER THE HOME OFFICE CONTRACTOR NAME AND CONTRACTOR NUMBER.

141	NAME:	CONTRACTOR'S NAME:	CONTRACTOR'S NUMBER:	141
142	STREET:	P.O. BOX:		142
143	CITY:	STATE:	ZIP CODE:	143
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?		Y	144
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.		N	145
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. (SEE CMS PUB. 15-2, SECTION 4020). IF YES, ENTER THE APPROVAL DATE (MM/DD/YYYY) IN COLUMN 2.		N	146
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	147
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	148
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.		N	149

DOES THIS FACILITY CONTAIN A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES? ENTER 'Y' FOR YES OR 'N' FOR NO FOR EACH COMPONENT FOR PART A AND PART B. SEE 42 CFR §413.13)

	TITLE XVIII	TITLE	TITLE	
	PART A	PART B	V	XIX
	1	2	3	4
155	HOSPITAL	N	N	N 155
156	SUBPROVIDER - IPF	N	N	156
157	SUBPROVIDER - IRF	N	N	157
158	SUBPROVIDER - (OTHER)	N	N	158
159	SNF	N	N	159
160	HHA	N	N	160
161	CMHC		N	161

MULTICAMPUS

165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N		165		
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.					
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
	0	1	2	3	4	5

HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT

167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y		167
168	IF THIS PROVIDER IS A CAH (LINE 105 IS 'Y') AND A MEANINGFUL USER (LINE 167 IS 'Y'), ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.	592,447		168
169	IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.			169

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY ALL HOSPITALS

		Y/N	DATE		
<b>PROVIDER ORGANIZATION AND OPERATION</b>					
1	HAS THE PROVIDER CHANGED OWNERSHIP IMMEDIATELY PRIOR TO THE BEGINNING OF THE COST REPORTING PERIOD? IF YES, ENTER THE DATE OF THE CHANGE IN COLUMN 2. (SEE INSTRUCTIONS)	1 N	2	1	
		Y/N	DATE	V/I	
2	HAS THE PROVIDER TERMINATED PARTICIPATION IN THE MEDICARE PROGRAM? IF YES, ENTER IN COLUMN 2 THE DATE OF TERMINATION AND IN COLUMN 3, 'V' FOR VOLUNTARY OR 'I' FOR INVOLUNTARY.	1 N	2	3 2	
3	IS THE PROVIDER INVOLVED IN BUSINESS TRANSACTIONS, INCLUDING MANAGEMENT CONTRACTS, WITH INDIVIDUALS OR ENTITIES (E.G., CHAIN HOME OFFICES, DRUG OR MEDICAL SUPPLY COMPANIES) THAT ARE RELATED TO THE PROVIDER OR ITS OFFICERS, MEDICAL STAFF, MANAGEMENT PERSONNEL, OR MEMBERS OF THE BOARD OF DIRECTORS THROUGH OWNERSHIP, CONTROL, OR FAMILY AND OTHER SIMILAR RELATIONSHIPS? (SEE INSTRUCTIONS)	Y		3	
<b>FINANCIAL DATA AND REPORTS</b>					
		Y/N	TYPE	DATE	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (SEE INSTRUCTIONS). IF NO, SEE INSTRUCTIONS.	1 Y	2 A	3 4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5	
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
		Y/N	Y/N		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	1 N	2	6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
			Y/N	Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.		Y	12	
13	IF LINE 12 IS YES, DID THE PROVIDER'S BAD DEBT COLLECTION POLICY CHANGE DURING THIS COST REPORTING PERIOD? IF YES, SUBMIT COPY.		N	13	
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.		N	14	
<b>BED COMPLEMENT</b>					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15	
<b>PS&amp;R REPORT DATA</b>					
		PART A		PART B	
		Y/N	DATE	Y/N	DATE
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	1 N	2	3 N	4 16
17	WAS THE COST REPORT PREPARED USING THE PS&R REPORT FOR TOTALS AND THE PROVIDER'S RECORDS FOR ALLOCATION? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE IN COLUMNS 2 AND 4. (SEE INSTRUCTIONS)	Y	07/12/2012	Y	07/12/2012 17
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	Y		Y	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

HOSPITAL AND HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
 PART II

GENERAL INSTRUCTION: ENTER Y FOR ALL YES RESPONSES. ENTER N FOR ALL NO RESPONSES.  
 ENTER ALL DATES IN THE MM/DD/YYYY FORMAT.

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COST

- 22 HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS. Y 22
- 23 HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 23
- 24 WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. Y 24
- 25 HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 25
- 26 WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 26
- 27 HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 27

INTEREST EXPENSE

- 28 WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. N 28
- 29 DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (DEBT SERVICE RESERVE FUND) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS. Y 29
- 30 HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS. N 30
- 31 HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS. N 31

PURCHASED SERVICES

- 32 HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS. N 32
- 33 IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS. 33

PROVIDER-BASED PHYSICIANS

- 34 ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS. Y 34
- 35 IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS. Y 35

HOME OFFICE COSTS

- |   | Y/N | DATE |
|---|-----|------|
|   | 1   | 2    |
| 36 WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?   | N   |      |
| 37 IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  |     |      |
| 38 IF LINE 36 IS YES, WAS THE FISCAL YEAR END OF THE HOME OFFICE DIFFERENT FROM THAT OF THE PROVIDER? IF YES, ENTER IN COLUMN 2 THE FISCAL YEAR END OF THE HOME OFFICE. | N   |      |
| 39 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.   |     |      |
| 40 IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.  |     |      |

COST REPORT PREPARER CONTACT INFORMATION

- |  |                 |        |    |
|--|-----------------|--------|----|
| 41 FIRST NAME: MARK DALLAS               | LAST NAME:      | TITLE: | 41 |
| 42 EMPLOYER: KERBER, ECK & BRAECKEL, LLP |                 |        | 42 |
| 43 PHONE NUMBER: 618-529-1040            | E-MAIL ADDRESS: |        | 43 |





HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
 PART II & III

PART II - WAGE DATA

	WKST A LINE NUMBER	AMOUNT REPORTED	RECLASS OF SALARIES (FROM WKST A-6)	ADJUSTED SALARIES (COL. 2 + COL. 3)	PAID HOURS RELATED TO SALARIES IN COL. 4	AVERAGE HOURLY WAGE (COL. 4 + COL. 5)
	1	2	3	4	5	6
SALARIES						
1	TOTAL SALARIES (SEE INSTRUCTIONS)	200	7,724,403			1
2	NON-PHYSICIAN ANESTHETIST PART A					2
3	NON-PHYSICIAN ANESTHETIST PART B					3
4	PHYSICIAN-PART A					4
4.01	PHYSICIANS-PART A - DIRECT TEACHING					4.01
5	PHYSICIAN-PART B					5
6	NON-PHYSICIAN-PART B					6
7	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)	21				7
7.01	CONTRACTED INTERNS & RESIDENTS (IN APPROVED PROGRAMS)					7.01
8	HOME OFFICE PERSONNEL					8
9	SNF	44				9
10	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)		447,374			10
OTHER WAGES & RELATED COSTS						
11	CONTRACT LABOR (SEE INSTRUCTIONS)					11
12	MANAGEMENT AND ADMINISTRATIVE SERVICES					12
13	CONTRACT LABOR: PHYSICIAN-PART A					13
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS					14
15	HOME OFFICE: PHYSICIAN-PART A					15
16	TEACHING PHYSICIAN SALARIES (SEE INSTRUCTIONS)					16
WAGE-RELATED COSTS						
17	WAGE-RELATED COSTS (CORE)					17
18	WAGE-RELATED COSTS (OTHER)					18
19	EXCLUDED AREAS					19
20	NON-PHYSICIAN ANESTHETIST PART A					20
21	NON-PHYSICIAN ANESTHETIST PART B					21
22	PHYSICIAN PART A					22
23	PHYSICIAN PART B					23
24	WAGE-RELATED COSTS (RHC/FQHC)					24
25	INTERNS & RESIDENTS (IN AN APPROVED PROGRAM)					25
OVERHEAD COSTS - DIRECT SALARIES						
26	EMPLOYEE BENEFITS		103,386			26
27	ADMINISTRATIVE & GENERAL		1,116,099			27
28	ADMINISTRATIVE & GENERAL UNDER CONTACT (SEE INST.)					28
29	MAINTENANCE & REPAIRS					29
30	OPERATION OF PLANT		274,798			30
31	LAUNDRY & LINEN SERVICE		38,170			31
32	HOUSEKEEPING		128,283			32
33	HOUSEKEEPING UNDER CONTRACT (SEE INSTRUCTIONS)					33
34	DIETARY		251,057	-185,050		34
35	DIETARY UNDER CONTRACT (SEE INSTRUCTIONS)					35
36	CAFETERIA			185,050		36
37	MAINTENANCE OF PERSONNEL					37
38	NURSING ADMINISTRATION		53,193			38
39	CENTRAL SERVICES AND SUPPLY		99,280	-15,548		39
40	PHARMACY		56,718			40
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		215,740			41
42	SOCIAL SERVICE		45,631			42
43	OTHER GENERAL SERVICE					43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	7,724,403		7,724,403		1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	447,374		447,374		2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	7,277,029		7,277,029		3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (SEE INST.)					4
5	SUBTOTAL WAGE-RELATED COSTS (SEE INST.)					5
6	TOTAL (SUM OF LINES 3 THRU 5)	7,277,029		7,277,029		6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	2,382,355	-15,548	2,366,807		7

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3  
PART IV

PART A - CORE LIST

	AMOUNT REPORTED
RETIREMENT COST	
1 401K EMPLOYER CONTRIBUTIONS	1
2 TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION	2
3 QUALIFIED AND NON-QUALIFIED PENSION PLAN COST	3
4 PRIOR YEAR PENSION SERVICE COST	4
PLAN ADMINISTRATIVE COSTS (PAID TO EXTERNAL ORGANIZATION)	
5 401K/TSA PLAN ADMINISTRATION FEES	5
6 LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	6
7 EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES	7
HEALTH AND INSURANCE COST	
8 HEALTH INSURANCE (PURCHASED OR SELF FUNDED)	8
9 PRESCRIPTION DRUG PLAN	9
10 DENTAL, HEARING AND VISION PLAN	10
11 LIFE INSURANCE (IF EMPLOYER IS OWNER OR BENEFICIARY)	11
12 ACCIDENTAL INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	12
13 DISABILITY INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	13
14 LONG-TERM CARE INSURANCE (IF EMPLOYEE IS OWNER OR BENEFICIARY)	14
15 WORKERS' COMPENSATION INSURANCE	15
16 RETIREMENT HEALTH CARE COST (ONLY CURRENT YEAR, NOT THE EXTRAORDINARY ACCRUAL REQUIRED BY FASB 106. NON CUMULATIVE PORTION)	16
TAXES	
17 FICA-EMPLOYERS PORTION ONLY	17
18 MEDICARE TAXES - EMPLOYERS PORTION ONLY	18
19 UNEMPLOYMENT INSURANCE	19
20 STATE OR FEDERAL UNEMPLOYMENT TAXES	20
OTHER	
21 EXECUTIVE DEFERRED COMPENSATION	21
22 DAY CARE COSTS AND ALLOWANCES	22
23 TUITION REIMBURSEMENT	23
24 TOTAL WAGE RELATED COST (SUM OF LINES 1-23)	24
PART B - OTHER THAN CORE RELATED COST	
25 OTHER WAGE RELATED (OTHER WAGE RELATED COST)	25

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
08/27/2012 15:17

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3  
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION

COMPONENT		CONTRACT	BENEFIT
0		LABOR	COST
		1	2
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST		1
2	HOSPITAL		2
3	SUBPROVIDER - IPF		3
4	SUBPROVIDER - IRF		4
5	SUBPROVIDER - (OTHER)		5
6	SWING BEDS - SNF		6
7	SWING BEDS - NF		7
8	HOSPITAL-BASED SNF		8
9	HOSPITAL-BASED NF		9
10	HOSPITAL-BASED OLTC		10
11	HOSPITAL-BASED HHA		11
12	SEPARATELY CERTIFIED ASC		12
13	HOSPITAL-BASED HOSPICE		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC		14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC		15
16	HOSPITAL-BASED (CMHC)		16
17	RENAL DIALYSIS		17
18	OTHER		18

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		Y/N	DATE	
		1	2	
1	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, WERE ALL PATIENTS UNDER MANAGED CARE OR WAS THERE NO MEDICARE UTILIZATION? ENTER 'Y' FOR YES IN COLUMN 1 AND DO NOT COMPLETE THE REST OF THIS WORKSHEET.	N		1
2	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	Y	12/17/1986	2

	GROUP	SNF DAYS	SWING BED SNF DAYS	TOTAL (COLS. 2 + 3)
	1	2	3	4
3	RUX			3
4	RUL			4
5	RVX			5
6	RVL			6
7	RHX			7
8	RHL			8
9	RMX			9
10	RML			10
11	RLX			11
12	RUC			12
13	RUB			13
14	RUA			14
15	RVC			15
16	RVB			16
17	RVA			17
18	RHC			18
19	RHB			19
20	RHA			20
21	RMC			21
22	RMB			22
23	RMA			23
24	RLB			24
25	RLA			25
26	ES3			26
27	ES2			27
28	ES1			28
29	HE2			29
30	HE1			30
31	HD2			31
32	HD1			32
33	HC2			33
34	HC1			34
35	HB2			35
36	HB1			36
37	LE2			37
38	LE1			38
39	LD2			39
40	LD1			40
41	LC2			41
42	LC1			42
43	LB2			43
44	LB1			44
45	CE2			45
46	CE1			46
47	CD2			47
48	CD1			48
49	CC2			49
50	CC1			50
51	CB2			51
52	CB1			52
53	CA2			53
54	CA1			54
55	SE3			55
56	SE2			56
57	SE1			57
58	SSC			58
59	SSB			59
60	SSA			60
61	IB2			61
62	IB1			62
63	IA1			63
64	IA2			64
65	BB2			65
66	BB1			66
67	BA2			67
68	BA1			68

PROSPECTIVE PAYMENT FOR SNF  
 STATISTICAL DATA

WORKSHEET S-7

		SNF	SWING BED	TOTAL
		DAYS	SNF DAYS	(COLS.
		2	3	2 + 3)
GROUP		4		
1				
69	PE2			69
70	PE1			70
71	PD2			71
72	PD1			72
73	PC2			73
74	PC1			74
75	PB2			75
76	PB1			76
77	PA2			77
78	PA1			78
199	AAA			199
200	TOTAL			200

		CBSA AT	CBSA
		BEGINNING	ON/AFTER
		OF COST	OF THE COST
		REPORTING	REPORTING
		PERIOD	PERIOD (IF
		1	APPLICABLE)
		2	2
201	ENTER IN COLUMN 1 THE SNF CBSA CODE, OR 5 CHARACTER NON-CBSA CODE IF A RURAL FACILITY, IN EFFECT AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER IN COLUMN 2 THE CODE IN EFFECT ON OR AFTER OCTOBER 1 OF THE COST REPORTING PERIOD (IF APPLICABLE).		201

A NOTICE PUBLISHED IN THE FEDERAL REGISTER VOLUME 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. FOR LINES 202 THROUGH 207: ENTER IN COLUMN 1 THE AMOUNT OF THE EXPENSE FOR EACH CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)

		EXPENSES	PERCENTAGE	ASSOCIATED
		1	2	WITH
				DIRECT
				PATIENT
				CARE AND
				RELATED
				EXPENSES?
		1	2	3
202	STAFFING			202
203	RECRUITMENT			203
204	RETENTION OF EMPLOYEES			204
205	TRAINING			205
206	OTHER (SPECIFY)			206
207	TOTAL SNF REVENUE (WORKSHEET G-2, PART I, LINE 7, COLUMN 3)			207

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
08/27/2012 15:17

RHC I  
COMPONENT NO: 14-3413

WORKSHEET S-8

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

CHECK APPLICABLE BOX: [XX] RHC [ ] FQHC

CLINIC ADDRESS AND IDENTIFICATION:

1 STREET: 1201 RICKER DRIVE 1  
2 CITY: SALEM STATE: IL ZIP CODE: 62881 COUNTY: MARION 2  
3 FQHCs ONLY: DESIGNATION - ENTER 'R' FOR RURAL OR 'U' FOR URBAN 3

SOURCE OF FEDERAL FUNDS: GRANT AWARD DATE  
1 2  
4 COMMUNITY HEALTH CENTER (SECTION 330(d), PHS ACT) 4  
5 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT) 5  
6 HEALTH SERVICES FOR HOMELESS (SECTION 340(d), PHS ACT) 6  
7 APPALACHIAN REGIONAL COMMISSION 7  
8 LOOK-ALIKES 8  
9 OTHER 9

10 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? 1 2  
IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2. N 10

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	
0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11 CLINIC															11

(1) ENTER CLINIC HOURS OF OPERATION ON LINE 11 AND OTHER TYPE OPERATIONS ON SUBSCRIPTS OF LINE 11 (BOTH TYPE AND HOURS 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.

12 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? 1 2  
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? N 12  
ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE N 13  
NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND

14 PROVIDER NAME: CCN NUMBER: 14

15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO Y/N V XVIII XIX 15  
IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED N  
BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)

HOSPITAL UNCOMPENSATED CARE AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (WKST C, PART I, LINE 200, COL. 3 DIVIDED BY LINE 200, COL. 8)				0.459574	1																																																																																																									
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)																																																																																																															
2	NET REVENUE FROM MEDICAID				1,111,698	2																																																																																																									
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				Y	3																																																																																																									
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?				N	4																																																																																																									
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID				610,097	5																																																																																																									
6	MEDICAID CHARGES				6,263,800	6																																																																																																									
7	MEDICAID COST (LINE 1 TIMES LINE 6)				2,878,680	7																																																																																																									
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5)				1,156,885	8																																																																																																									
STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP) (SEE INSTRUCTIONS FOR EACH LINE)																																																																																																															
9	NET REVENUE FROM STAND-ALONE SCHIP					9																																																																																																									
10	STAND-ALONE SCHIP CHARGES					10																																																																																																									
11	STAND-ALONE SCHIP COST (LINE 1 TIMES LINE 10)					11																																																																																																									
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (LINE 11 MINUS LINE 9)					12																																																																																																									
OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (SEE INSTRUCTIONS FOR EACH LINE)																																																																																																															
13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED ON LINES 2, 5, OR 9)					13																																																																																																									
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (NOT INCLUDED IN LINES 6 OR 10)					14																																																																																																									
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (LINE 1 TIMES LINE 14)					15																																																																																																									
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (LINE 15 MINUS LINE 13)					16																																																																																																									
UNCOMPENSATED CARE (SEE INSTRUCTIONS FOR EACH LINE)																																																																																																															
17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE					17																																																																																																									
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS					18																																																																																																									
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (SUM OF LINES 8, 12 AND 16)				1,156,885	19																																																																																																									
<table border="0" style="width: 100%;"> <thead> <tr> <th></th> <th></th> <th style="text-align: center;">UNINSURED</th> <th style="text-align: center;">INSURED</th> <th></th> <th></th> <th></th> </tr> <tr> <th></th> <th></th> <th style="text-align: center;">PATIENTS</th> <th style="text-align: center;">PATIENTS</th> <th></th> <th></th> <th style="text-align: center;">TOTAL</th> </tr> <tr> <th></th> <th></th> <th style="text-align: center;">1</th> <th style="text-align: center;">2</th> <th></th> <th></th> <th style="text-align: center;">3</th> </tr> </thead> <tbody> <tr> <td>20</td> <td>TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY</td> <td style="text-align: right;">334,996</td> <td style="text-align: right;">115,786</td> <td></td> <td></td> <td style="text-align: right;">450,782</td> </tr> <tr> <td>21</td> <td>COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)</td> <td style="text-align: right;">153,955</td> <td style="text-align: right;">53,212</td> <td></td> <td></td> <td style="text-align: right;">207,167</td> </tr> <tr> <td>22</td> <td>PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE</td> <td style="text-align: right;">50,244</td> <td style="text-align: right;">21,232</td> <td></td> <td></td> <td style="text-align: right;">71,476</td> </tr> <tr> <td>23</td> <td>COST OF CHARITY CARE</td> <td style="text-align: right;">103,711</td> <td style="text-align: right;">31,980</td> <td></td> <td></td> <td style="text-align: right;">135,691</td> </tr> <tr> <td>24</td> <td>DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM</td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: center;">N 24</td> </tr> <tr> <td>25</td> <td>IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)</td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: center;">25</td> </tr> <tr> <td>26</td> <td>TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)</td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">1,076,251</td> </tr> <tr> <td>27</td> <td>MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V</td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">555,631</td> </tr> <tr> <td>28</td> <td>NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)</td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">520,620</td> </tr> <tr> <td>29</td> <td>COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)</td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">239,263</td> </tr> <tr> <td>30</td> <td>COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)</td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">374,954</td> </tr> <tr> <td>31</td> <td>TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)</td> <td></td> <td></td> <td></td> <td></td> <td style="text-align: right;">1,531,839</td> </tr> </tbody> </table>									UNINSURED	INSURED						PATIENTS	PATIENTS			TOTAL			1	2			3	20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (AT FULL CHARGES EXCLUDING NON-REIMBURSABLE COST CENTERS) FOR THE ENTIRE FACILITY	334,996	115,786			450,782	21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	153,955	53,212			207,167	22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	50,244	21,232			71,476	23	COST OF CHARITY CARE	103,711	31,980			135,691	24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM					N 24	25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (SEE INSTRUCTIONS)					25	26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS)					1,076,251	27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V					555,631	28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)					520,620	29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)					239,263	30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)					374,954	31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)					1,531,839
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL (COL. 1 + COL. 2)	RECLASSIFI- CATIONS	
		1	2	3	4	
GENERAL SERVICE COST CENTERS						
1	00100		1,239,414	1,239,414	467,593	1
2	00200		898,186	898,186	718,597	2
3	00300					3
4	00400	103,386	1,837,431	1,940,817		4
5.01	00592	494,532	2,971,660	3,466,192	-480,279	5.01
5.02	00591	621,567	473,627	1,095,194		5.02
6	00600					6
7	00700					7
8	00800	274,798	623,315	898,113	-7,071	8
9	00900	38,170	23,089	61,259		9
10	01000	128,283	84,548	212,831		10
11	01100	251,057	400,896	651,953	-481,472	11
12	01200				480,545	12
13	01300					13
14	01400	53,193	13,599	66,792		14
14.01	01401	83,732	12,711	96,443		14.01
14.02	01402	15,548	605,742	621,290	-621,290	14.02
15	01500					15
16	01600	56,718	1,111,868	1,168,586		16
17	01700	215,740	180,319	396,059	-1,841	17
19	01900	45,631	8,824	54,455		19
20	02000				457,107	20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,578,966	215,972	1,794,938	-10,267	30
31	03100					31
ANCILLARY SERVICE COST CENTERS						
50	05000	609,412	392,488	1,001,900	-99,417	50
53	05300	197,340	302,460	499,800	-499,800	53
54	05400	705,082	1,075,756	1,780,838	-504,582	54
60	06000	557,497	858,834	1,416,331	-15,429	60
62.30	06250					62.30
65	06500	296,512	216,888	513,400	-12,614	65
66	06600		757,309	757,309	-770	66
67	06700					67
68	06800					68
69	06900	39,795	54,048	93,843		69
71	07100				621,290	71
73	07300					73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	357,879	37,789	395,668	91,391	88
90	09000	135,197	22,206	157,403	-100	90
90.01	09001					90.01
91	09100	774,873	2,059,802	2,834,675	-101,591	91
92	09200					92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910					99.10
99.20	09920					99.20
99.30	09930					99.30
99.40	09940					99.40
118		7,634,908	16,478,781	24,113,689		118
NONREIMBURSABLE COST CENTERS						
190	19000	47,517	52,772	100,289		190
192	19200	41,978	3,742	45,720		192
192.01	19201					192.01
200		7,724,403	16,535,295	24,259,698		200

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		RECLASSIFIED TRIAL BALANCE (COL. 3 ± COL. 4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL. 5 ± COL. 6) 7		
GENERAL SERVICE COST CENTERS						
1	00100	CAP REL COSTS-BLDG & FIXT	1,707,007		1,707,007	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,616,783	-134,281	1,482,502	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	1,940,817	-63,255	1,877,562	4
5.01	00592	ADMINISTRATIVE & ACCOUNTING	2,985,913	-1,853,234	1,132,679	5.01
5.02	00591	BUSINESS SERVICES	1,095,194	-27,088	1,068,106	5.02
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	891,042		891,042	7
8	00800	LAUNDRY & LINEN SERVICE	61,259		61,259	8
9	00900	HOUSEKEEPING	212,831		212,831	9
10	01000	DIETARY	170,481	-27,616	142,865	10
11	01100	CAFETERIA	480,545	-118,916	361,629	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	66,792		66,792	13
14	01400	CENTRAL SERVICES & SUPPLY				14
14.01	01401	PURCHASING	96,443		96,443	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY				14.02
15	01500	PHARMACY	1,168,586	-404	1,168,182	15
16	01600	MEDICAL RECORDS & LIBRARY	394,218	-17	394,201	16
17	01700	SOCIAL SERVICE	54,455		54,455	17
19	01900	NONPHYSICIAN ANESTHETISTS	457,107	-457,107		19
20	02000	NURSING SCHOOL				20
21	02100	I&R SRVCES-SALARY & FRINGES APPRVD				21
22	02200	I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23	02300	PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	ADULTS & PEDIATRICS	1,784,671		1,784,671	30
31	03100	INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	902,483		902,483	50
53	05300	ANESTHESIOLOGY				53
54	05400	RADIOLOGY-DIAGNOSTIC	1,276,256		1,276,256	54
60	06000	LABORATORY	1,400,902		1,400,902	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	500,786	-62,122	438,664	65
66	06600	PHYSICAL THERAPY	756,539	-1,248	755,291	66
67	06700	OCCUPATIONAL THERAPY				67
68	06800	SPEECH PATHOLOGY				68
69	06900	ELECTROCARDIOLOGY	93,843	-45,268	48,575	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	621,290		621,290	71
73	07300	DRUGS CHARGED TO PATIENTS				73
76.97	07697	CARDIAC REHABILITATION				76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				76.98
76.99	07699	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	RURAL HEALTH CLINIC (RHC)	487,059		487,059	88
90	09000	CLINIC	157,303		157,303	90
90.01	09001	SALEM MEDICAL CLINIC				90.01
91	09100	EMERGENCY	2,733,084	-828,912	1,904,172	91
92	09200	OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS						
118		SUBTOTALS (SUM OF LINES 1-117)	24,113,689	-3,619,468	20,494,221	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	100,289		100,289	190
192	19200	PHYSICIANS' PRIVATE OFFICES	45,720		45,720	192
192.01	19201	TEMPORARILY IDLE SPACE				192.01
200		TOTAL (SUM OF LINES 118-199)	24,259,698	-3,619,468	20,640,230	200

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER
	1	2	3	4	5
1 TO RECLASS CAFETERIA COST	A	CAFETERIA	11	185,050	295,495 1
500 TOTAL RECLASSIFICATIONS				185,050	295,495 500
CODE LETTER - A					
1 TO RECLASS SUPPLY COST	B	MEDICAL SUPPLIES CHRGED TO PA	71	15,548	605,742 1
500 TOTAL RECLASSIFICATIONS				15,548	605,742 500
CODE LETTER - B					
1 TO RECLASS RENTALS	C	CAP REL COSTS-MVBLE EQUIP	2		718,597 1
2					2
3					3
4					4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12					12
500 TOTAL RECLASSIFICATIONS					718,597 500
CODE LETTER - C					
1 TO RECLASS CRNA COST	D	NONPHYSICIAN ANESTHETISTS	19		457,107 1
500 TOTAL RECLASSIFICATIONS					457,107 500
CODE LETTER - D					
1 TO RECLASS REMAINING ANESTHESIA SUPP	E	OPERATING ROOM	50		42,693 1
500 TOTAL RECLASSIFICATIONS					42,693 500
CODE LETTER - E					
1 TO RECLASS INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		397,336 1
500 TOTAL RECLASSIFICATIONS					397,336 500
CODE LETTER - F					
1 TO RECLASS PHYSICIAN PORTION FOR RHC	G	RURAL HEALTH CLINIC (RHC)	88		91,391 1
500 TOTAL RECLASSIFICATIONS					91,391 500
CODE LETTER - G					
1 TO RECLASS OTHER CAPITAL COSTS	H	CAP REL COSTS-BLDG & FIXT	1		70,257 1
500 TOTAL RECLASSIFICATIONS					70,257 500
CODE LETTER - H					
GRAND TOTAL (INCREASES)				200,598	2,678,618

RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE LINE #	SALARY	OTHER	WKST A-7 REF.
	1	6	7	8	9	10
1 TO RECLASS CAFETERIA COST	A	DIETARY	10	185,050	295,495	1
500 TOTAL RECLASSIFICATIONS				185,050	295,495	500
CODE LETTER - A						
1 TO RECLASS SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	14.02	15,548	605,742	1
500 TOTAL RECLASSIFICATIONS				15,548	605,742	500
CODE LETTER - B						
1 TO RECLASS RENTALS	C	ADMINISTRATIVE & ACCOUNTING	5.01		12,686	10 1
2		OPERATION OF PLANT	7		7,071	2
3		DIETARY	10		927	3
4		MEDICAL RECORDS & LIBRARY	16		1,841	4
5		ADULTS & PEDIATRICS	30		10,267	5
6		OPERATING ROOM	50		142,110	6
7		RADIOLOGY-DIAGNOSTIC	54		504,582	7
8		LABORATORY	60		15,429	8
9		RESPIRATORY THERAPY	65		12,614	9
10		PHYSICAL THERAPY	66		770	10
11		CLINIC	90		100	11
12		EMERGENCY	91		10,200	12
500 TOTAL RECLASSIFICATIONS					718,597	500
CODE LETTER - C						
1 TO RECLASS CRNA COST	D	ANESTHESIOLOGY	53		457,107	1
500 TOTAL RECLASSIFICATIONS					457,107	500
CODE LETTER - D						
1 TO RECLASS REMAINING ANESTHESIA SUPP	E	ANESTHESIOLOGY	53		42,693	1
500 TOTAL RECLASSIFICATIONS					42,693	500
CODE LETTER - E						
1 TO RECLASS INTEREST EXPENSE	F	ADMINISTRATIVE & ACCOUNTING	5.01		397,336	14 1
500 TOTAL RECLASSIFICATIONS					397,336	500
CODE LETTER - F						
1 TO RECLASS PHYSICIAN PORTION FOR RHC	G	EMERGENCY	91		91,391	1
500 TOTAL RECLASSIFICATIONS					91,391	500
CODE LETTER - G						
1 TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	5.01		70,257	14 1
500 TOTAL RECLASSIFICATIONS					70,257	500
CODE LETTER - H						
GRAND TOTAL (DECREASES)				200,598	2,678,618	

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN 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	61,161					61,161	1
2 LAND IMPROVEMENTS	932,114	1,900		1,900	20,936	913,078	2
3 BUILDINGS AND FIXTURES	21,436,374	8,255,651		8,255,651	5,748,071	23,943,954	3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT	1,560,753	503,428		503,428	165,887	1,898,294	5
6 MOVABLE EQUIPMENT	8,925,371	807,184		807,184	92,887	9,639,668	6
7 HIT DESIGNATED ASSETS							7
8 SUBTOTAL (SUM OF LINES 1-7)	32,915,773	9,568,163		9,568,163	6,027,781	36,456,155	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	32,915,773	9,568,163		9,568,163	6,027,781	36,456,155	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(1)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,239,414						1,239,414 1
2 CAP REL COSTS-MVBLE EQUIP	898,186						898,186 2
3 TOTAL (SUM OF LINES 1-2)	2,137,600						2,137,600 3

PART III - RECONCILIATION OF CAPITAL COST CENTERS

----- COMPUTATION OF RATIOS ----- ALLOCATION OF OTHER CAPITAL -----

DESCRIPTION	GROSS ASSETS 1	CAPITALIZED LEASES 2	GROSS ASSETS FOR RATIO (COL. 1 - COL. 2) 3	RATIO (SEE INSTR.) 4	INSURANCE 5	TAXES 6	OTHER CAPITAL- RELATED COSTS 7	TOTAL
								(SUM OF COLS. 5-7) 8
1 CAP REL COSTS-BLDG & FIXT								1
2 CAP REL COSTS-MVBLE EQUIP								2
3 TOTAL (SUM OF LINES 1-2)								3

----- SUMMARY OF CAPITAL -----

DESCRIPTION	DEPREC- IATION 9	LEASE 10	INTEREST 11	INSURANCE (SEE INSTR.) 12	TAXES (SEE INSTR.) 13	OTHER CAPITAL- RELATED COSTS (SEE INSTR.) 14	TOTAL(2)
							(SUM OF COLS. 9-14) 15
1 CAP REL COSTS-BLDG & FIXT	1,239,414					467,593	1,707,007 1
2 CAP REL COSTS-MVBLE EQUIP	898,186	718,597				-134,281	1,482,502 2
3 TOTAL	2,137,600	718,597				333,312	3,189,509 3

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-BUILDINGS & FIXTURES (CHAPTER 2)			CAP REL COSTS-BLDG & FIXT	1	1
2 INVESTMENT INCOME-MOVABLE EQUIPMENT (CHAPTER 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3 INVESTMENT INCOME-OTHER (CHAPTER 2)	B	-8,553	ADMINISTRATIVE & ACCOUNTING	5.01	3
4 TRADE, QUANTITY, AND TIME DISCOUNTS (CHAPTER 8)					4
5 REFUNDS AND REBATES OF EXPENSES (CHAPTER 8)					5
6 RENTAL OF PROVIDER SPACE BY SUPPLIERS (CHAPTER 8)					6
7 TELEPHONE SERVICES (PAY STATIONS EXCL) (CHAPTER 21)	A	-1,636	ADMINISTRATIVE & ACCOUNTING	5.01	7
8 TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-1,842	ADMINISTRATIVE & ACCOUNTING	5.01	8
9 PARKING LOT (CHAPTER 21)					9
10 PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-936,302			10
11 SALE OF SCRAP, WASTE, ETC. (CHAPTER 23)					11
12 RELATED ORGANIZATION TRANSACTIONS (CHAPTER 10)	WKST A-8-1				12
13 LAUNDRY AND LINEN SERVICE					13
14 CAFETERIA - EMPLOYEES AND GUESTS	B	-118,916	CAFETERIA	11	14
15 RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16 SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17 SALE OF DRUGS TO OTHER THAN PATIENTS	B	-404	PHARMACY	15	17
18 SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-17	MEDICAL RECORDS & LIBRARY	16	18
19 NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20 VENDING MACHINES					20
21 INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)					21
22 INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT					22
23 ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3				23
24 ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25 UTIL REVIEW-PHYSICIANS' COMPENSATION (CHAPTER 21)					25
26 DEPRECIATION--BUILDINGS & FIXTURES			UTILIZATION REVIEW-SNF	114	26
27 DEPRECIATION--MOVABLE EQUIPMENT	B	-133,838	CAP REL COSTS-BLDG & FIXT	1	27
28 NON-PHYSICIAN ANESTHETIST		-457,107	CAP REL COSTS-MVBLE EQUIP	2	14
29 PHYSICIANS' ASSISTANT			NONPHYSICIAN ANESTHETISTS	19	28
30 ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	29
31 ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68	30
32 CAH HIT ADJ FOR DEPRECIATION AND					31
33 PROVISION FOR BAD DEBTS	A	-1,811,531	ADMINISTRATIVE & ACCOUNTING	5.01	32
34 DIETARY REVENUE	B	-27,616	DIETARY	10	33
35 BUS OFFICE COSTS ASSOC W/ PHYS CHG	A	-27,088	BUSINESS SERVICES	5.02	34
36 TELEPHONE	A	-443	CAP REL COSTS-MVBLE EQUIP	2	14
37 PHYSICIAN RECRUITMENT	A	-123,190	ADMINISTRATIVE & ACCOUNTING	5.01	35
38 OTHER REVENUE	B	-478	ADMINISTRATIVE & ACCOUNTING	5.01	36
39 LOBBYING PORTION OF DUES	A	-10,249	ADMINISTRATIVE & ACCOUNTING	5.01	37
40 MARKETING	A	-63,255	EMPLOYEE BENEFITS	4	38
41 OTHER REVENUE	B	-639	ADMINISTRATIVE & ACCOUNTING	5.01	39
42 SPOUSE MEAL COST	A	-74	ADMINISTRATIVE & ACCOUNTING	5.01	40
43 ATHLETIC TRAINER	A	-1,248	PHYSICAL THERAPY	66	41
44 ADVERTISING	A	-168	ADMINISTRATIVE & ACCOUNTING	5.01	42
45 HEALTHLINK ADMIN FEES	B	105,126	ADMINISTRATIVE & ACCOUNTING	5.01	43
46					44
47					45
48					46
49					47
50 TOTAL (SUM OF LINES 1 THRU 49)		-3,619,468			48
TRANSFER TO WKST A, COL. 6, LINE 200)					49

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 (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						1
2						2
3						3
4						4
5	TOTALS (SUM OF LINES 1-4)					5
	TRANSFER COL. 6, LINE 5 TO					
	WKST A-8, COL. 2, LINE 12.					

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	
6						6
7						7
8						8
9						9
10						10

- (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	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1 50	OPERATING ROOM	OR	24,000		24,000			1
2 60	LABORATORY	LABORATORY	35,500		35,500			2
3 65	RESPIRATORY THERAPY	RESPIRATORY THE	420	420				3
4 65	RESPIRATORY THERAPY	RESPIRATORY THE	61,702	61,702				4
5 69	ELECTROCARDIOLOGY	ELECTROCARDIOLO	45,268	45,268				5
6 91	EMERGENCY	EMERGENCY	1,818,987	828,912	990,075			6
200	TOTAL		1,985,877	936,302	1,049,575			200

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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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	50 OPERATING ROOM								1
2	60 LABORATORY								2
3	65 RESPIRATORY THERAPY							420	3
4	65 RESPIRATORY THERAPY							61,702	4
5	69 ELECTROCARDIOLOGY							45,268	5
6	91 EMERGENCY							828,912	6
200	TOTAL							936,302	200

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES  
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3  
PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					15	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					225	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		376.00				9
10	AHSEA		68.48				10
11	STANDARD TRAVEL ALLOWANCE	34.24	34.24				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					25,748	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					25,748	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					25,748	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					25,748	23

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

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

WORKSHEET A-8-3  
PARTS III & IV

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

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

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

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

STANDARD TRAVEL EXPENSE

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

OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE

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

TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES

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

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

WORKSHEET A-8-3  
PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					25,748	SALARY EQUIVALENCY AMOUNT 57
58						TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE 58
59						TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES 59
60						OVERTIME ALLOWANCE 60
61						EQUIPMENT COST 61
62						SUPPLIES 62
63					25,748	TOTAL ALLOWANCE 63
64					17,657	TOTAL COST OF OUTSIDE SUPPLIER SERVICES 64
65						EXCESS OVER LIMITATION 65

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

WORKSHEET A-8-3  
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)				52	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK				780	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE					3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE					4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS					5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS					6
7	STANDARD TRAVEL EXPENSE RATE				5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
		1	2	3	4	5
9	TOTAL HOURS WORKED		4,764.00		4,706.00	9
10	AHSEA		72.25		52.54	10
11	STANDARD TRAVEL ALLOWANCE	36.13	36.13			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				344,199	15
16	ASSISTANTS					16
17	SUBTOTAL ALLOWANCE AMOUNT				344,199	17
18	AIDES				247,253	18
19	TRAINEES					19
20	TOTAL ALLOWANCE AMOUNT				591,452	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					22
23	TOTAL SALARY EQUIVALENCY				591,452	23

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

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

WORKSHEET A-8-3  
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

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
08/27/2012 15:17

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

WORKSHEET A-8-3  
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						OVERTIME HOURS WORKED 47
						DURING REPORTING PERIOD
48						OVERTIME RATE 48
49						TOTAL OVERTIME 49
						CALCULATION OF LIMIT
50						PERCENTAGE OF OVERTIME 50
						HOURS BY CATEGORY
51						ALLOCATION OF PROVIDER'S 51
						STANDARD WORKYEAR FOR ONE
						FULL TIME EMPLOYEE TIMES
						THE PERCENTAGES ON LINE 50
						DETERMINATION OF OVERTIME ALLOWANCE
52						ADJUSTED HOURLY SALARY 52
						EQUIVALENCY AMOUNT
53						OVERTIME COST LIMITATION 53
54						MAXIMUM OVERTIME COST 54
55						PORTION OF OVERTIME ALREADY 55
						INCLUDED IN HOURLY
						COMPUTATION AT THE AHSEA
56						OVERTIME ALLOWANCE 56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					591,452	SALARY EQUIVALENCY AMOUNT 57
58						TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE 58
59						TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES 59
60						OVERTIME ALLOWANCE 60
61						EQUIPMENT COST 61
62						SUPPLIES 62
63					591,452	TOTAL ALLOWANCE 63
64					381,815	TOTAL COST OF OUTSIDE SUPPLIER SERVICES 64
65						EXCESS OVER LIMITATION 65

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
08/27/2012 15:17

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

WORKSHEET A-8-3  
PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					14	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					210	2
3	NUMBER OF UNDUPLICATED DAYS ON WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE						3
4	NUMBER OF UNDUPLICATED DAYS ON WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS						6
7	STANDARD TRAVEL EXPENSE RATE					5.00	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		42.00				9
10	AHSEA		65.80				10
11	STANDARD TRAVEL ALLOWANCE	32.90	32.90				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					2,764	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					2,764	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					2,764	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES					65.81	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES					13,820	22
23	TOTAL SALARY EQUIVALENCY					13,820	23

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
08/27/2012 15:17

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

WORKSHEET A-8-3  
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 CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

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

WORKSHEET A-8-3  
 PARTS V,VI & VII

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

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					13,820	SALARY EQUIVALENCY AMOUNT 57
58						TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE 58
59						TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES 59
60						OVERTIME ALLOWANCE 60
61						EQUIPMENT COST 61
62						SUPPLIES 62
63					13,820	TOTAL ALLOWANCE 63
64					5,034	TOTAL COST OF OUTSIDE SUPPLIER SERVICES 64
65						EXCESS OVER LIMITATION 65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ALLOCATION	CAP	CAP	EMPLOYEE	SUBTOTAL	
	(FROM WKST A, COL.7) 0	BLDGS & FIXTURES 1	MOVABLE EQUIPMENT 2	BENEFITS 4		
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,707,007	1,707,007				1
2 CAP REL COSTS-MVBLE EQUIP	1,482,502		1,482,502			2
4 EMPLOYEE BENEFITS	1,877,562	9,687	2,183	1,889,432		4
5.01 ADMINISTRATIVE & ACCOUNTING	1,132,679	467,693	23,493	122,606	1,746,471	5.01
5.02 BUSINESS SERVICES	1,068,106	102,250	283,713	154,101	1,608,170	5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	891,042	196,376	30,850	68,129	1,186,397	7
8 LAUNDRY & LINEN SERVICE	61,259	15,115	2,554	9,463	88,391	8
9 HOUSEKEEPING	212,831	13,174		31,804	257,809	9
10 DIETARY	142,865	48,763	4,760	16,365	212,753	10
11 CAFETERIA	361,629			45,878	407,507	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	66,792	27,345	5,054	13,188	112,379	13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING	96,443	23,016	428	20,759	140,646	14.01
14.02 CENTRAL SERVICES & SUPPLY						14.02
15 PHARMACY	1,168,182	12,762		14,062	1,195,006	15
16 MEDICAL RECORDS & LIBRARY	394,201	30,848	28,897	53,487	507,433	16
17 SOCIAL SERVICE	54,455			11,313	65,768	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	1,784,671	94,246	60,545	391,463	2,330,925	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	902,483	104,277	214,368	200,013	1,421,141	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,276,256	57,987	662,033	174,807	2,171,083	54
60 LABORATORY	1,400,902	105,342	81,624	138,217	1,726,085	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	438,664	55,668	22,587	73,512	590,431	65
66 PHYSICAL THERAPY	755,291	96,582	6,694		858,567	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	48,575		7,425	9,866	65,866	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	621,290	16,489	380	3,855	642,014	71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	487,059	22,260	388	88,727	598,434	88
90 CLINIC	157,303	13,518	819	33,519	205,159	90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	1,904,172	75,970	33,712	192,110	2,205,964	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	20,494,221	1,589,368	1,472,507	1,867,244	20,344,399	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	100,289	17,863	4,800	11,781	134,733	190
192 PHYSICIANS' PRIVATE OFFICES	45,720	23,617	5,195	10,407	84,939	192
192.01 TEMPORARILY IDLE SPACE		76,159			76,159	192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	20,640,230	1,707,007	1,482,502	1,889,432	20,640,230	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	ADMINISTRATIVE & ACCOUNTING 5.01	BUSINESS SERVICES 5.02	OPERATION OF PLANT 7	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING 9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & ACCOUNTING	1,746,471					5.01
5.02 BUSINESS SERVICES	148,653	1,756,823				5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	109,666		1,296,063			7
8 LAUNDRY & LINEN SERVICE	8,171		20,122	116,684		8
9 HOUSEKEEPING	23,831		17,538	4,638	303,816	9
10 DIETARY	19,666		64,915	793	7,403	10
11 CAFETERIA	37,668					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	10,388		36,402			13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING	13,001		30,640			14.01
14.02 CENTRAL SERVICES & SUPPLY					10,179	14.02
15 PHARMACY	110,462		16,989		8,020	15
16 MEDICAL RECORDS & LIBRARY	46,905		41,066		4,010	16
17 SOCIAL SERVICE	6,079					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	215,470	106,534	125,463	65,102	116,281	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	131,365	103,348	139,068	14,440	32,695	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	200,686	558,514	77,194	12,041	27,451	54
60 LABORATORY	159,552	411,353	140,234		15,114	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	54,577	101,981	74,107		7,094	65
66 PHYSICAL THERAPY	79,362	88,015	128,573	5,484	15,114	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	6,088	28,800			5,244	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	59,345	72,999	21,951	293		71
73 DRUGS CHARGED TO PATIENTS		102,803				73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	55,317	24,136	21,494			88
90 CLINIC	18,964	21,197	10,061			90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	203,910	137,143	90,776	13,893	33,312	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	1,719,126	1,756,823	1,056,593	116,684	281,917	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,454		23,780			190
192 PHYSICIANS' PRIVATE OFFICES	7,851		62,674		21,899	192
192.01 TEMPORARILY IDLE SPACE	7,040		153,016			192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,746,471	1,756,823	1,296,063	116,684	303,816	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	
	10	11	13	14.01	14.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & ACCOUNTING						5.01
5.02 BUSINESS SERVICES						5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	305,530					10
11 CAFETERIA		445,175				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		3,688	162,857			13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING		7,340		191,627		14.01
14.02 CENTRAL SERVICES & SUPPLY				327	10,506	14.02
15 PHARMACY		6,208		1,441		15
16 MEDICAL RECORDS & LIBRARY		20,668		1,185		16
17 SOCIAL SERVICE		2,739		11		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	305,530	127,077	84,318	12,113		30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		42,761	26,299	26,177		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		52,657		25,196		54
60 LABORATORY		51,123		105,452		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		26,913		4,112		65
66 PHYSICAL THERAPY				1,397	24	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY				650		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		2,374			10,482	71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		25,562	16,445	1,618		88
90 CLINIC		10,188		1,887		90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY		54,958	35,795	8,981		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	305,530	434,256	162,857	190,547	10,506	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,902		1,035		190
192 PHYSICIANS' PRIVATE OFFICES		4,017		45		192
192.01 TEMPORARILY IDLE SPACE						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	305,530	445,175	162,857	191,627	10,506	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 ADMINISTRATIVE & ACCOUNTING					5.01
5.02 BUSINESS SERVICES					5.02
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
14.01 PURCHASING					14.01
14.02 CENTRAL SERVICES & SUPPLY					14.02
15 PHARMACY	1,338,126				15
16 MEDICAL RECORDS & LIBRARY		621,267			16
17 SOCIAL SERVICE			74,597		17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS		235,946	74,597	3,799,356	30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		39,458		1,976,752	50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC		42,277		3,167,099	54
60 LABORATORY		159,041		2,767,954	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		24,963		884,178	65
66 PHYSICAL THERAPY		36,237		1,212,773	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY		12,079		118,727	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				809,458	71
73 DRUGS CHARGED TO PATIENTS	1,338,126			1,440,929	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		10,871		753,877	88
90 CLINIC				267,456	90
90.01 SALEM MEDICAL CLINIC					90.01
91 EMERGENCY		60,395		2,845,127	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	1,338,126	621,267	74,597	20,043,686	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				178,904	190
192 PHYSICIANS' PRIVATE OFFICES				181,425	192
192.01 TEMPORARILY IDLE SPACE				236,215	192.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	1,338,126	621,267	74,597	20,640,230	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION		TOTAL	
		26	
GENERAL SERVICE COST CENTERS			
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	ADMINISTRATIVE & ACCOUNTING		5.01
5.02	BUSINESS SERVICES		5.02
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
14.01	PURCHASING		14.01
14.02	CENTRAL SERVICES & SUPPLY		14.02
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
INPATIENT ROUTINE SERV COST CENTERS			
30	ADULTS & PEDIATRICS	3,799,356	30
31	INTENSIVE CARE UNIT		31
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	1,976,752	50
53	ANESTHESIOLOGY		53
54	RADIOLOGY-DIAGNOSTIC	3,167,099	54
60	LABORATORY	2,767,954	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	884,178	65
66	PHYSICAL THERAPY	1,212,773	66
67	OCCUPATIONAL THERAPY		67
68	SPEECH PATHOLOGY		68
69	ELECTROCARDIOLOGY	118,727	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	809,458	71
73	DRUGS CHARGED TO PATIENTS	1,440,929	73
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
OUTPATIENT SERVICE COST CENTERS			
88	RURAL HEALTH CLINIC (RHC)	753,877	88
90	CLINIC	267,456	90
90.01	SALEM MEDICAL CLINIC		90.01
91	EMERGENCY	2,845,127	91
92	OBSERVATION BEDS		92
OTHER REIMBURSABLE COST CENTERS			
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
SPECIAL PURPOSE COST CENTERS			
118	SUBTOTALS (SUM OF LINES 1-117)	20,043,686	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	178,904	190
192	PHYSICIANS' PRIVATE OFFICES	181,425	192
192.01	TEMPORARILY IDLE SPACE	236,215	192.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	20,640,230	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIR ASSGND	CAP	CAP	SUBTOTAL	EMPLOYEE	
	CAP-REL COSTS	BLDGS & FIXTURES	MOVABLE EQUIPMENT		BENEFITS	
	0	1	2	2A	4	
GENERAL SERVICE COST CENTERS						
1						1
2						2
4						4
5.01		9,687	2,183	11,870	11,870	4
5.01		467,693	23,493	491,186	770	5.01
5.02		102,250	283,713	385,963	968	5.02
6						6
7		196,376	30,850	227,226	428	7
8		15,115	2,554	17,669	59	8
9		13,174		13,174	200	9
10		48,763	4,760	53,523	103	10
11					288	11
12						12
13		27,345	5,054	32,399	83	13
14						14
14.01		23,016	428	23,444	130	14.01
14.02						14.02
15		12,762		12,762	88	15
16		30,848	28,897	59,745	336	16
17					71	17
19						19
20						20
21						21
22						22
23						23
INPATIENT ROUTINE SERV COST CENTERS						
30		94,246	60,545	154,791	2,458	30
31						31
ANCILLARY SERVICE COST CENTERS						
50		104,277	214,368	318,645	1,257	50
53						53
54		57,987	662,033	720,020	1,099	54
60		105,342	81,624	186,966	869	60
62.30						62.30
65		55,668	22,587	78,255	462	65
66		96,582	6,694	103,276		66
67						67
68						68
69			7,425	7,425	62	69
71		16,489	380	16,869	24	71
73						73
76.97						76.97
76.98						76.98
76.99						76.99
OUTPATIENT SERVICE COST CENTERS						
88		22,260	388	22,648	558	88
90		13,518	819	14,337	211	90
90.01						90.01
91		75,970	33,712	109,682	1,207	91
92						92
OTHER REIMBURSABLE COST CENTERS						
99.10						99.10
99.20						99.20
99.30						99.30
99.40						99.40
SPECIAL PURPOSE COST CENTERS						
118		1,589,368	1,472,507	3,061,875	11,731	118
NONREIMBURSABLE COST CENTERS						
190		17,863	4,800	22,663	74	190
192		23,617	5,195	28,812	65	192
192.01		76,159		76,159		192.01
200						200
201						201
202		1,707,007	1,482,502	3,189,509	11,870	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	ADMINISTRATIVE & ACCOUNTING	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	
	5.01	5.02	7	8	9	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & ACCOUNTING	491,956					5.01
5.02 BUSINESS SERVICES	41,874	428,805				5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	30,891		258,545			7
8 LAUNDRY & LINEN SERVICE	2,302		4,014	24,044		8
9 HOUSEKEEPING	6,713		3,499	956	24,542	9
10 DIETARY	5,540		12,950	163	598	10
11 CAFETERIA	10,611					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	2,926		7,262			13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING	3,662		6,112			14.01
14.02 CENTRAL SERVICES & SUPPLY					822	14.02
15 PHARMACY	31,116		3,389		648	15
16 MEDICAL RECORDS & LIBRARY	13,213		8,192		324	16
17 SOCIAL SERVICE	1,712					17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	60,690	26,003	25,028	13,416	9,392	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	37,004	25,225	27,742	2,975	2,641	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	56,531	136,325	15,399	2,481	2,218	54
60 LABORATORY	44,944	100,402	27,975		1,221	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	15,374	24,891	14,783		573	65
66 PHYSICAL THERAPY	22,355	21,482	25,648	1,130	1,221	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	1,715	7,029			424	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	16,717	17,817	4,379	60		71
73 DRUGS CHARGED TO PATIENTS		25,092				73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	15,582	5,891	4,288			88
90 CLINIC	5,342	5,174	2,007			90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	57,439	33,474	18,108	2,863	2,691	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	484,253	428,805	210,775	24,044	22,773	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,508		4,744			190
192 PHYSICIANS' PRIVATE OFFICES	2,212		12,503		1,769	192
192.01 TEMPORARILY IDLE SPACE	1,983		30,523			192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	491,956	428,805	258,545	24,044	24,542	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	
	10	11	13	14.01	14.02	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & ACCOUNTING						5.01
5.02 BUSINESS SERVICES						5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY	72,877					10
11 CAFETERIA		10,899				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		90	42,760			13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING		180		33,528		14.01
14.02 CENTRAL SERVICES & SUPPLY				57	879	14.02
15 PHARMACY		152		252		15
16 MEDICAL RECORDS & LIBRARY		506		207		16
17 SOCIAL SERVICE		67		2		17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	72,877	3,111	22,139	2,119		30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		1,047	6,905	4,580		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		1,289		4,408		54
60 LABORATORY		1,252		18,453		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		659		719		65
66 PHYSICAL THERAPY				244	2	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY				114		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		58			877	71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		626	4,318	283		88
90 CLINIC		249		330		90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY		1,346	9,398	1,571		91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	72,877	10,632	42,760	33,339	879	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		169		181		190
192 PHYSICIANS' PRIVATE OFFICES		98		8		192
192.01 TEMPORARILY IDLE SPACE						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	72,877	10,899	42,760	33,528	879	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	SUBTOTAL 24	I&R COST & POST STEP-DOWN ADJS 25
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 ADMINISTRATIVE & ACCOUNTING					5.01
5.02 BUSINESS SERVICES					5.02
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
14.01 PURCHASING					14.01
14.02 CENTRAL SERVICES & SUPPLY					14.02
15 PHARMACY	48,407				15
16 MEDICAL RECORDS & LIBRARY		82,523			16
17 SOCIAL SERVICE			1,852		17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES APPRVD					21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS		31,342	1,852	425,218	30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		5,241		433,262	50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC		5,616		945,386	54
60 LABORATORY		21,125		403,207	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		3,316		139,032	65
66 PHYSICAL THERAPY		4,813		180,171	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY		1,604		18,373	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				56,801	71
73 DRUGS CHARGED TO PATIENTS	48,407			73,499	73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)		1,444		55,638	88
90 CLINIC				27,650	90
90.01 SALEM MEDICAL CLINIC					90.01
91 EMERGENCY		8,022		245,801	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	48,407	82,523	1,852	3,004,038	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				31,339	190
192 PHYSICIANS' PRIVATE OFFICES				45,467	192
192.01 TEMPORARILY IDLE SPACE				108,665	192.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	48,407	82,523	1,852	3,189,509	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
 PART II

COST CENTER DESCRIPTION		TOTAL	
		26	
	GENERAL SERVICE COST CENTERS		
1	CAP REL COSTS-BLDG & FIXT		1
2	CAP REL COSTS-MVBLE EQUIP		2
4	EMPLOYEE BENEFITS		4
5.01	ADMINISTRATIVE & ACCOUNTING		5.01
5.02	BUSINESS SERVICES		5.02
6	MAINTENANCE & REPAIRS		6
7	OPERATION OF PLANT		7
8	LAUNDRY & LINEN SERVICE		8
9	HOUSEKEEPING		9
10	DIETARY		10
11	CAFETERIA		11
12	MAINTENANCE OF PERSONNEL		12
13	NURSING ADMINISTRATION		13
14	CENTRAL SERVICES & SUPPLY		14
14.01	PURCHASING		14.01
14.02	CENTRAL SERVICES & SUPPLY		14.02
15	PHARMACY		15
16	MEDICAL RECORDS & LIBRARY		16
17	SOCIAL SERVICE		17
19	NONPHYSICIAN ANESTHETISTS		19
20	NURSING SCHOOL		20
21	I&R SRVCES-SALARY & FRINGES APPRVD		21
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		22
23	PARAMED ED PRGM-(SPECIFY)		23
	INPATIENT ROUTINE SERV COST CENTERS		
30	ADULTS & PEDIATRICS	425,218	30
31	INTENSIVE CARE UNIT		31
	ANCILLARY SERVICE COST CENTERS		
50	OPERATING ROOM	433,262	50
53	ANESTHESIOLOGY		53
54	RADIOLOGY-DIAGNOSTIC	945,386	54
60	LABORATORY	403,207	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	139,032	65
66	PHYSICAL THERAPY	180,171	66
67	OCCUPATIONAL THERAPY		67
68	SPEECH PATHOLOGY		68
69	ELECTROCARDIOLOGY	18,373	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	56,801	71
73	DRUGS CHARGED TO PATIENTS	73,499	73
76.97	CARDIAC REHABILITATION		76.97
76.98	HYPERBARIC OXYGEN THERAPY		76.98
76.99	LITHOTRIPSY		76.99
	OUTPATIENT SERVICE COST CENTERS		
88	RURAL HEALTH CLINIC (RHC)	55,638	88
90	CLINIC	27,650	90
90.01	SALEM MEDICAL CLINIC		90.01
91	EMERGENCY	245,801	91
92	OBSERVATION BEDS		92
	OTHER REIMBURSABLE COST CENTERS		
99.10	CORF		99.10
99.20	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	OUTPATIENT SPEECH PATHOLOGY		99.40
	SPECIAL PURPOSE COST CENTERS		
118	SUBTOTALS (SUM OF LINES 1-117)	3,004,038	118
	NONREIMBURSABLE COST CENTERS		
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,339	190
192	PHYSICIANS' PRIVATE OFFICES	45,467	192
192.01	TEMPORARILY IDLE SPACE	108,665	192.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	3,189,509	202

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS GROSS SALARIES	RECON-CILIATION	ADMINISTRATIVE & ACCOUNTING ACCUM COST	
	1	2	4	5A.01	5.01	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	99,382					1
2 CAP REL COSTS-MVBLE EQUIP		1,616,780				2
4 EMPLOYEE BENEFITS	564	2,381	7,621,016			4
5.01 ADMINISTRATIVE & ACCOUNTING	27,229	25,621	494,531	-1,746,471	18,893,759	5.01
5.02 BUSINESS SERVICES	5,953	309,411	621,567		1,608,170	5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	11,433	33,644	274,798		1,186,397	7
8 LAUNDRY & LINEN SERVICE	880	2,785	38,170		88,391	8
9 HOUSEKEEPING	767		128,283		257,809	9
10 DIETARY	2,839	5,191	66,007		212,753	10
11 CAFETERIA			185,050		407,507	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,592	5,512	53,193		112,379	13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING	1,340	467	83,732		140,646	14.01
14.02 CENTRAL SERVICES & SUPPLY						14.02
15 PHARMACY	743		56,718		1,195,006	15
16 MEDICAL RECORDS & LIBRARY	1,796	31,514	215,740		507,433	16
17 SOCIAL SERVICE			45,631		65,768	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,487	66,029	1,578,966		2,330,925	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,071	233,784	806,752		1,421,141	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	3,376	721,997	705,082		2,171,083	54
60 LABORATORY	6,133	89,017	557,497		1,726,085	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,241	24,633	296,512		590,431	65
66 PHYSICAL THERAPY	5,623	7,300			858,567	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		8,097	39,795		65,866	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	960	414	15,548		642,014	71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	1,296	423	357,879		598,434	88
90 CLINIC	787	893	135,197		205,159	90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	4,423	36,766	774,873		2,205,964	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	92,533	1,605,879	7,531,521	-1,746,471	18,597,928	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,040	5,235	47,517		134,733	190
192 PHYSICIANS' PRIVATE OFFICES	1,375	5,666	41,978		84,939	192
192.01 TEMPORARILY IDLE SPACE	4,434				76,159	192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,707,007	1,482,502	1,889,432		1,746,471	202
203 UNIT COST MULT-WS B PT I	17.176219	0.916947	0.247924		0.092436	203
204 COST TO BE ALLOC PER B PT II			11,870		491,956	204
205 UNIT COST MULT-WS B PT II			0.001558		0.026038	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	BUSINESS S	OPERATION	LAUNDRY	HOUSE-	DIETARY
	ERVICES	OF PLANT	& LINEN	KEEPING	
	GROSS CHAR	SQUARE	SERVICE	HOURS OF	MEALS
	GES	FEET	POUNDS OF	SERVICE	SERVED
	5.02	7	8	9	10
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 ADMINISTRATIVE & ACCOUNTING					5.01
5.02 BUSINESS SERVICES	43,488,449				5.02
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT		56,682			7
8 LAUNDRY & LINEN SERVICE		880	17,511		8
9 HOUSEKEEPING		767	696	985	9
10 DIETARY		2,839	119	24	8,718
11 CAFETERIA					10
12 MAINTENANCE OF PERSONNEL					11
13 NURSING ADMINISTRATION		1,592			12
14 CENTRAL SERVICES & SUPPLY					13
14.01 PURCHASING		1,340			14
14.02 CENTRAL SERVICES & SUPPLY				33	14.01
15 PHARMACY		743		26	14.02
16 MEDICAL RECORDS & LIBRARY		1,796		13	15
17 SOCIAL SERVICE					16
19 NONPHYSICIAN ANESTHETISTS					17
20 NURSING SCHOOL					19
21 I&R SRVCES-SALARY & FRINGES APPRVD					20
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					21
23 PARAMED ED PRGM-(SPECIFY)					22
INPATIENT ROUTINE SERV COST CENTERS					23
30 ADULTS & PEDIATRICS	2,637,188	5,487	9,770	377	8,718
31 INTENSIVE CARE UNIT					30
ANCILLARY SERVICE COST CENTERS					31
50 OPERATING ROOM	2,558,309	6,082	2,167	106	50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	13,825,115	3,376	1,807	89	54
60 LABORATORY	10,182,754	6,133		49	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	2,524,473	3,241		23	65
66 PHYSICAL THERAPY	2,178,751	5,623	823	49	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	712,929			17	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	1,807,031	960	44		71
73 DRUGS CHARGED TO PATIENTS	2,544,815				73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)	597,476	940			88
90 CLINIC	524,721	440			90
90.01 SALEM MEDICAL CLINIC					90.01
91 EMERGENCY	3,394,887	3,970	2,085	108	91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)	43,488,449	46,209	17,511	914	8,718
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1,040			190
192 PHYSICIANS' PRIVATE OFFICES		2,741		71	192
192.01 TEMPORARILY IDLE SPACE		6,692			192.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 COST TO BE ALLOC PER B PT I	1,756,823	1,296,063	116,684	303,816	305,530
203 UNIT COST MULT-WS B PT I	0.040397	22.865513	6.663469	308.442640	35.045882
204 COST TO BE ALLOC PER B PT II	428,805	258,545	24,044	24,542	72,877
205 UNIT COST MULT-WS B PT II	0.009860	4.561325	1.373080	24.915736	8.359371

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING	PURCHASING	CENTRAL	PHARMACY	
	MEALS SERVED	ADMINIS- TRATION DIRECT NRSING HRS	COSTED REQUIS.	SERVICES & SUPPLY COSTED REQ UIS.	COSTED REQUIS.	
	11	13	14.01	14.02	15	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT						1
2 CAP REL COSTS-MVBLE EQUIP						2
4 EMPLOYEE BENEFITS						4
5.01 ADMINISTRATIVE & ACCOUNTING						5.01
5.02 BUSINESS SERVICES						5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT						7
8 LAUNDRY & LINEN SERVICE						8
9 HOUSEKEEPING						9
10 DIETARY						10
11 CAFETERIA	12,191					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	101	143,691				13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING	201		1,043,147			14.01
14.02 CENTRAL SERVICES & SUPPLY			1,782	592,927		14.02
15 PHARMACY	170		7,844		100	15
16 MEDICAL RECORDS & LIBRARY	566		6,452			16
17 SOCIAL SERVICE	75		62			17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCES-SALARY & FRINGES APPRVD						21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,480	74,395	65,938			30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,171	23,204	142,496			50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,442		137,160			54
60 LABORATORY	1,400		574,035			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	737		22,385			65
66 PHYSICAL THERAPY			7,603	1,330		66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY			3,538			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	65			591,597		71
73 DRUGS CHARGED TO PATIENTS					100	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	700	14,510	8,809			88
90 CLINIC	279		10,274			90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	1,505	31,582	48,887			91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS						
118 SUBTOTALS (SUM OF LINES 1-117)	11,892	143,691	1,037,265	592,927	100	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	189		5,635			190
192 PHYSICIANS' PRIVATE OFFICES	110		247			192
192.01 TEMPORARILY IDLE SPACE						192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	445,175	162,857	191,627	10,506	1,338,126	202
203 UNIT COST MULT-WS B PT I	36.516693	1.133383	0.183701	0.017719	13,381.260000	203
204 COST TO BE ALLOC PER B PT II	10,899	42,760	33,528	879	48,407	204
205 UNIT COST MULT-WS B PT II	0.894020	0.297583	0.032141	0.001482	484.070000	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY		SOCIAL SERVICE	
	TIME SPENT		TIME SPENT	
	16		17	
GENERAL SERVICE COST CENTERS				
1 CAP REL COSTS-BLDG & FIXT				1
2 CAP REL COSTS-MVBLE EQUIP				2
4 EMPLOYEE BENEFITS				4
5.01 ADMINISTRATIVE & ACCOUNTING				5.01
5.02 BUSINESS SERVICES				5.02
6 MAINTENANCE & REPAIRS				6
7 OPERATION OF PLANT				7
8 LAUNDRY & LINEN SERVICE				8
9 HOUSEKEEPING				9
10 DIETARY				10
11 CAFETERIA				11
12 MAINTENANCE OF PERSONNEL				12
13 NURSING ADMINISTRATION				13
14 CENTRAL SERVICES & SUPPLY				14
14.01 PURCHASING				14.01
14.02 CENTRAL SERVICES & SUPPLY				14.02
15 PHARMACY				15
16 MEDICAL RECORDS & LIBRARY	1,543			16
17 SOCIAL SERVICE		3,285		17
19 NONPHYSICIAN ANESTHETISTS				19
20 NURSING SCHOOL				20
21 I&R SRVCES-SALARY & FRINGES APPRVD				21
22 I&R SRVCES-OTHER PRGM COSTS APPRVD				22
23 PARAMED ED PRGM-(SPECIFY)				23
INPATIENT ROUTINE SERV COST CENTERS				
30 ADULTS & PEDIATRICS	586	3,285		30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	98			50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	105			54
60 LABORATORY	395			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	62			65
66 PHYSICAL THERAPY	90			66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	30			69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				71
73 DRUGS CHARGED TO PATIENTS				73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)	27			88
90 CLINIC				90
90.01 SALEM MEDICAL CLINIC				90.01
91 EMERGENCY	150			91
92 OBSERVATION BEDS				92
OTHER REIMBURSABLE COST CENTERS				
99.10 CORF				99.10
99.20 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
118 SUBTOTALS (SUM OF LINES 1-117)	1,543	3,285		118
NONREIMBURSABLE COST CENTERS				
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				190
192 PHYSICIANS' PRIVATE OFFICES				192
192.01 TEMPORARILY IDLE SPACE				192.01
200 CROSS FOOT ADJUSTMENTS				200
201 NEGATIVE COST CENTER				201
202 COST TO BE ALLOC PER B PT I	621,267	74,597		202
203 UNIT COST MULT-WS B PT I	402.635774	22.708371		203
204 COST TO BE ALLOC PER B PT II	82,523	1,852		204
205 UNIT COST MULT-WS B PT II	53.482178	0.563775		205

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 26) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	3,799,356		3,799,356		3,799,356	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,976,752		1,976,752		1,976,752	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	3,167,099		3,167,099		3,167,099	54
60 LABORATORY	2,767,954		2,767,954		2,767,954	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	884,178		884,178		884,178	65
66 PHYSICAL THERAPY	1,212,773		1,212,773		1,212,773	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	118,727		118,727		118,727	69
71 MEDICAL SUPPLIES CHRGED TO	809,458		809,458		809,458	71
73 DRUGS CHARGED TO PATIENTS	1,440,929		1,440,929		1,440,929	73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)	753,877		753,877		753,877	88
90 CLINIC	267,456		267,456		267,456	90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	2,845,127		2,845,127		2,845,127	91
92 OBSERVATION BEDS	128,508		128,508		128,508	92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	20,172,194		20,172,194		20,172,194	200
201 LESS OBSERVATION BEDS	128,508		128,508		128,508	201
202 TOTAL (SEE INSTRUCTIONS)	20,043,686		20,043,686		20,043,686	202

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 (COLS. 6 + 7) 8			
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	2,637,188		2,637,188			30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	385,783	2,172,526	2,558,309	0.772679	0.772679	0.772679 50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,148,277	12,676,838	13,825,115	0.229083	0.229083	0.229083 54
60 LABORATORY	1,385,305	8,797,449	10,182,754	0.271828	0.271828	0.271828 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,147,393	1,377,080	2,524,473	0.350243	0.350243	0.350243 65
66 PHYSICAL THERAPY	186,350	1,992,401	2,178,751	0.556637	0.556637	0.556637 66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	47,006	665,923	712,929	0.166534	0.166534	0.166534 69
71 MEDICAL SUPPLIES CHRGED TO	510,242	1,296,789	1,807,031	0.447949	0.447949	0.447949 71
73 DRUGS CHARGED TO PATIENTS	1,003,684	1,541,131	2,544,815	0.566222	0.566222	0.566222 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)		597,476	597,476			88
90 CLINIC	421	524,300	524,721	0.509711	0.509711	0.509711 90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	63,259	3,331,628	3,394,887	0.838062	0.838062	0.838062 91
92 OBSERVATION BEDS		125,161	125,161	1.026742	1.026742	1.026742 92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORF						99.10
99.20 OUTPATIENT PHYSICAL THERAPY						99.20
99.30 OUTPATIENT OCCUPATIONAL THE						99.30
99.40 OUTPATIENT SPEECH PATHOLOGY						99.40
200 SUBTOTAL (SEE INSTRUCTIONS)	8,514,908	35,098,702	43,613,610			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	8,514,908	35,098,702	43,613,610			202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1345) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PROGRAM CHARGES				PROGRAM COSTS		
		PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES SUBJECT TO DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7	
ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.772679		1,133,739			876,016		50
53 ANESTHESIOLOGY								53
54 RADIOLOGY-DIAGNOSTIC	0.229083		5,242,513			1,200,971		54
60 LABORATORY	0.271828		3,344,615			909,160		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.350243		580,463			203,303		65
66 PHYSICAL THERAPY	0.556637		811,217			451,553		66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.166534		366,501			61,035		69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.447949		584,725			261,927		71
73 DRUGS CHARGED TO PATIENTS	0.566222		962,378			544,920		73
76.97 CARDIAC REHABILITATION								76.97
76.98 HYPERBARIC OXYGEN THERAPY								76.98
76.99 LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS								
88 RURAL HEALTH CLINIC (RHC)								88
90 CLINIC	0.509711		261,897			133,492		90
90.01 SALEM MEDICAL CLINIC								90.01
91 EMERGENCY	0.838062		1,214,134			1,017,520		91
92 OBSERVATION BEDS	1.026742		80,124			82,267		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			14,582,306			5,742,164		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			14,582,306			5,742,164		202

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B-SNF (14-Z345)  
 APPLICABLE [XX] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [ ] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO	PPS	COST REIMB. SERVICES	COST REIMB. SVCES NOT SUBJECT TO	COST SERVICES SUBJECT TO	COST SVCES NOT SUBJECT TO	
	FROM WKST C, PT I, COL. 9	REIMBURSED SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS	PPS SERVICES	SUBJECT TO DED & COINS	SUBJECT TO DED & COINS
	1	2	3	4	5	6	7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.772679						50
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC	0.229083						54
60 LABORATORY	0.271828						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.350243						65
66 PHYSICAL THERAPY	0.556637						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.166534						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.447949						71
73 DRUGS CHARGED TO PATIENTS	0.566222						73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
90 CLINIC	0.509711						90
90.01 SALEM MEDICAL CLINIC							90.01
91 EMERGENCY	0.838062						91
92 OBSERVATION BEDS	1.026742						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

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	CAP-REL COST	REDUCED CAP-REL COST	TOTAL PATIENT DAYS	PER DIEM	INPAT PGM DAYS	INPAT PGM CAP COST
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT (COL. 1 MINUS COL. 2)	(COL. 1 MINUS COL. 2)	(COL. 3 ÷ COL. 4)	PGM DAYS	(COL. 5 x COL. 6)
	1	2	3	5	6	7
INPAT ROUTINE SERV COST CTRS						
30 ADULTS & PEDIATRICS	425,218	25,138	400,080	3,199	125.06	135
31 INTENSIVE CARE UNIT						16,883
32 CORONARY CARE UNIT						30
33 BURN INTENSIVE CARE UNIT						31
34 SURGICAL INTENSIVE CARE UNIT						32
35 OTHER SPECIAL CARE (SPECIFY)						33
40 SUBPROVIDER - IPF						34
41 SUBPROVIDER - IRF						35
42 SUBPROVIDER I						40
43 NURSERY						41
44 SKILLED NURSING FACILITY						42
45 NURSING FACILITY						43
200 TOTAL (LINES 30-199)	425,218		400,080	3,199		135
						16,883
						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK APPLICABLE BOXES	[ ] TITLE V [ ] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-1345) [ ] IPF [ ] IRF	[ ] SUB (OTHER)	[ ] PPS [ ] TEFRA [XX] OTHER				
		CAP-REL COST (FROM WKST B, PT. II, COL. 26) 1	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 2	RATIO OF COST TO CHARGES (COL.1 ÷ COL.2) 3	INPATIENT PROGRAM CHARGES 4	CAPITAL (COL.3 x COL.4) 5		
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	433,262	2,558,309	0.169355				50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	945,386	13,825,115	0.068382				54
60	LABORATORY	403,207	10,182,754	0.039597				60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	139,032	2,524,473	0.055074				65
66	PHYSICAL THERAPY	180,171	2,178,751	0.082695				66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	18,373	712,929	0.025771				69
71	MEDICAL SUPPLIES CHRGD TO PA	56,801	1,807,031	0.031433				71
73	DRUGS CHARGED TO PATIENTS	73,499	2,544,815	0.028882				73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC (RHC)	55,638	597,476	0.093122				88
90	CLINIC	27,650	524,721	0.052695				90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	245,801	3,394,887	0.072403				91
92	OBSERVATION BEDS	15,286	125,161	0.122131				92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	2,594,106	40,976,422					200

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 08/27/2012 15:17

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	NURSING SCHOOL 1	ALLIED HEALTH COST 2	ALL OTHER MEDICAL EDUCATION COST 3	SWING-BED ADJUSTMENT AMOUNT (SEE INSTR.) 4	TOTAL COSTS (SUM OF COLS. 1-3 MINUS COL. 4) 5
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)					200

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 08/27/2012 15:17

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	TOTAL PATIENT DAYS 6	PER DIEM COL.5 ÷ COL.6) 7	INPATIENT PROGRAM DAYS 8	INPAT PGM PASS THRU COSTS (COL.7 x COL.8) 9	
INPAT ROUTINE SERV COST CTRS					
30 ADULTS & PEDIATRICS	3,199		135		30
31 INTENSIVE CARE UNIT					31
32 CORONARY CARE UNIT					32
33 BURN INTENSIVE CARE UNIT					33
34 SURGICAL INTENSIVE CARE UNIT					34
35 OTHER SPECIAL CARE (SPECIFY)					35
40 SUBPROVIDER - IPF					40
41 SUBPROVIDER - IRF					41
42 SUBPROVIDER I					42
43 NURSERY					43
44 SKILLED NURSING FACILITY					44
45 NURSING FACILITY					45
200 TOTAL (SUM OF LINES 30-199)	3,199		135		200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

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

COST CENTER DESCRIPTION	NON	NURSING	ALLIED	ALL OTHER	TOTAL	TOTAL O/P
	PHYSICIAN			MEDICAL	COST	COST
	ANESTHETIST	SCHOOL	HEALTH	EDUCATION	(SUM OF	(SUM OF
	COST			COST	COLS.1-4)	COLS.2-4)
	1	2	3	4	5	6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
60 LABORATORY						60
62.30 BLOOD CLOTTING FOR HEMOPHILIA						62.30
65 RESPIRATORY THERAPY						65
66 PHYSICAL THERAPY						66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY						69
71 MEDICAL SUPPLIES CHRGED TO PA						71
73 DRUGS CHARGED TO PATIENTS						73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS						
88 RURAL HEALTH CLINIC (RHC)						88
90 CLINIC						90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY						91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
200 TOTAL (SUM OF LINES 50-199)						200

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK	[ ]	TITLE V	[XX]	HOSPITAL (14-1345)	[ ]	SUB (OTHER)	[ ]	ICF/MR	[ ]	PPS
APPLICABLE	[ ]	TITLE XVIII-PT A	[ ]	IPF	[ ]	SNF			[ ]	TEFRA
BOXES	[XX]	TITLE XIX	[ ]	IRF	[ ]	NF			[XX]	OTHER
COST CENTER DESCRIPTION	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8)	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7)	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7)	INPAT PGM CHARGES	INPAT PGM COSTS (COL. 8 x COL. 10)	O/P PGM CHARGES	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12)			
	7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS										
50 OPERATING ROOM	2,558,309						50			
53 ANESTHESIOLOGY							53			
54 RADIOLOGY-DIAGNOSTIC	13,825,115						54			
60 LABORATORY	10,182,754						60			
62.30 BLOOD CLOTTING FOR HEMOPHILI							62.30			
65 RESPIRATORY THERAPY	2,524,473						65			
66 PHYSICAL THERAPY	2,178,751						66			
67 OCCUPATIONAL THERAPY							67			
68 SPEECH PATHOLOGY							68			
69 ELECTROCARDIOLOGY	712,929						69			
71 MEDICAL SUPPLIES CHRGED TO P	1,807,031						71			
73 DRUGS CHARGED TO PATIENTS	2,544,815						73			
76.97 CARDIAC REHABILITATION							76.97			
76.98 HYPERBARIC OXYGEN THERAPY							76.98			
76.99 LITHOTRIPSY							76.99			
OUTPATIENT SERVICE COST CENTERS										
88 RURAL HEALTH CLINIC (RHC)	597,476						88			
90 CLINIC	524,721						90			
90.01 SALEM MEDICAL CLINIC							90.01			
91 EMERGENCY	3,394,887						91			
92 OBSERVATION BEDS	125,161						92			
OTHER REIMBURSABLE COST CENTERS										
200 TOTAL (SUM OF LINES 50-199)	40,976,422						200			

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D  
 PART V

CHECK [ ] TITLE V - O/P [XX] HOSPITAL (14-1345) [ ] SUB (OTHER) [ ] S/B-SNF  
 APPLICABLE [ ] TITLE XVIII-PT B [ ] IPF [ ] SNF [ ] S/B-NF  
 BOXES [XX] TITLE XIX - O/P [ ] IRF [ ] NF [ ] ICF/MR

COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COSTS		
	COST TO CHARGE RATIO FROM WKST C, PT I, COL. 9 1	PPS REIMBURSED SERVICES 2	COST REIMB. SERVICES DED & COINS 3	COST REIMB. SVCES NOT SUBJECT TO DED & COINS 4	COST SERVICES DED & COINS 5	COST SVCES NOT SUBJECT TO DED & COINS 6	COST SVCES NOT SUBJECT TO DED & COINS 7
ANCILLARY SERVICE COST CENTERS							
50 OPERATING ROOM	0.772679						50
53 ANESTHESIOLOGY							53
54 RADIOLOGY-DIAGNOSTIC	0.229083						54
60 LABORATORY	0.271828						60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 RESPIRATORY THERAPY	0.350243						65
66 PHYSICAL THERAPY	0.556637						66
67 OCCUPATIONAL THERAPY							67
68 SPEECH PATHOLOGY							68
69 ELECTROCARDIOLOGY	0.166534						69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.447949						71
73 DRUGS CHARGED TO PATIENTS	0.566222						73
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS							
88 RURAL HEALTH CLINIC (RHC)							88
90 CLINIC	0.509711						90
90.01 SALEM MEDICAL CLINIC							90.01
91 EMERGENCY	0.838062						91
92 OBSERVATION BEDS	1.026742						92
OTHER REIMBURSABLE COST CENTERS							
200 SUBTOTAL (SEE INSTRUCTIONS)							200
201 LESS PBP CLINIC LAB SERVICES							201
202 NET CHARGES (LINE 200 - LINE 201)							202

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1345) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,400	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,199	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,084	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	151	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	50	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,533	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 (SEE INSTRUCTIONS)	151	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	50	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
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	118.65	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,799,356	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	224,609	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,574,747	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,580,543	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,580,543	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.385269	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	836.75	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,574,747	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1345) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [ ] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,117.46 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,830,526 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 2,830,526 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 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
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					1,625,785 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					4,456,311 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 168,736 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 55,873 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 224,609 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 115 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,117.46 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 128,508 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST	425,218	3,574,747	0.118951	128,508	15,286 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

WORKSHEET D-1  
 PART I

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1345) [ ] SUB (OTHER) [ ] ICF/MR [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [ ] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS			
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS, EXCLUDING NEWBORN)	3,400	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,199	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,084	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	151	5
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	50	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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	135	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 (SEE INSTRUCTIONS)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		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 (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)		14
15	TOTAL NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		15
16	TITLE V OR XIX NURSERY DAYS (TITLE V OR TITLE XIX ONLY)		16
SWING-BED ADJUSTMENT			
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	118.65	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (SEE INSTRUCTIONS)	3,799,356	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 5 x LINE 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 6 x LINE 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 7 x LINE 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 8 x LINE 20)		25
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	224,609	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,574,747	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,580,543	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,580,543	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.385269	31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (LINE 29 ÷ LINE 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (LINE 30 ÷ LINE 4)	836.75	33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (LINE 32 MINUS LINE 33) (SEE INSTRUCTIONS)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (LINE 34 x LINE 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (LINE 3 x LINE 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (LINE 27 - LINE 36)	3,574,747	37

WORKSHEET D-1  
 PART II

COMPUTATION OF INPATIENT OPERATING COST

CHECK [ ] TITLE V-INPT [XX] HOSPITAL (14-1345) [ ] SUB (OTHER) [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] TEFRA  
 BOXES [XX] TITLE XIX-INPT [ ] IRF [XX] OTHER

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS  
 38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (SEE INSTRUCTIONS) 1,117.46 38  
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 150,857 39  
 40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (LINE 14 x LINE 35) 40  
 41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 39 + LINE 40) 150,857 41

	TOTAL INPATIENT COST 1	TOTAL INPATIENT DAYS 2	AVERAGE PER DIEM (COL. 1 ÷ COL. 2) 3	PROGRAM DAYS 4	PROGRAM COST (COL. 3 x COL. 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
48 PROGRAM INPATIENT ANCILLARY SERVICE COST (WKST D-3, COL. 3, LINE 200)					48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					150,857 49

PASS-THROUGH COST ADJUSTMENTS  
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 16,883 50  
 51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (FROM WKST D, SUM OF PARTS II AND IV) 51  
 52 TOTAL PROGRAM EXCLUDABLE COST 16,883 52  
 53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (LINE 49 MINUS LINE 52) 53

TARGET AMOUNT AND LIMIT COMPUTATION  
 54 PROGRAM DISCHARGES 54  
 55 TARGET AMOUNT PER DISCHARGE 55  
 56 TARGET AMOUNT (LINE 54 x LINE 55) 56  
 57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT 57  
 58 BONUS PAYMENT (SEE INSTRUCTIONS) 58  
 59 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET 59  
 60 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET 60  
 61 IF LINE 53/54 IS LESS THAN THE LOWER OF LINES 55, 59 OR 60 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 60), OR 1% OF THE TARGET AMOUNT (LINE 56), OTHERWISE ENTER ZERO (SEE INSTRUCTIONS) 61  
 62 RELIEF PAYMENT (SEE INSTRUCTIONS) 62  
 63 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS) 63

PROGRAM INPATIENT ROUTINE SWING BED COST  
 64 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 64  
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 65  
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 66  
 67 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 12 x LINE 19) 67  
 68 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (LINE 13 x LINE 20) 68  
 69 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (LINE 67 + LINE 68) 69

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87 TOTAL OBSERVATION BED DAYS (SEE INSTRUCTIONS) 115 87  
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 88  
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 89

	COST 1	ROUTINE COST (FROM LINE 27) 2	COL. 1 ÷ COL. 2 3	TOTAL OBS. BED COST (FROM LINE 89) 4	OBS. BED PASS-THRU COST (COL. 3 x COL. 4) (SEE INSTR.) 5
COMPUTATION OF OBSERVATION BED PASS-THROUGH COST					
90 CAPITAL-RELATED COST					90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-1345) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2)		
			3	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS		2,103,179			30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.772679	217,279	167,887		50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	0.229083	796,497	182,464		54
60 LABORATORY	0.271828	1,078,318	293,117		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.350243	936,776	328,099		65
66 PHYSICAL THERAPY	0.556637	82,727	46,049		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.166534	38,240	6,368		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.447949	329,294	147,507		71
73 DRUGS CHARGED TO PATIENTS	0.566222	796,720	451,120		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
90 CLINIC	0.509711				90
90.01 SALEM MEDICAL CLINIC					90.01
91 EMERGENCY	0.838062	3,787	3,174		91
92 OBSERVATION BEDS	1.026742				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		4,279,638	1,625,785		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		4,279,638			202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [ ] HOSPITAL [ ] SUB (OTHER) [XX] S/B SNF (14-Z345) [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3		
INPATIENT ROUTINE SERVICE COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	0.772679				50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	0.229083	2,180	499		54
60 LABORATORY	0.271828	26,185	7,118		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	0.350243	17,760	6,220		65
66 PHYSICAL THERAPY	0.556637	98,095	54,603		66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY	0.166534	260	43		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.447949	28,578	12,801		71
73 DRUGS CHARGED TO PATIENTS	0.566222	43,520	24,642		73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
OUTPATIENT SERVICE COST CENTERS					
88 RURAL HEALTH CLINIC (RHC)					88
90 CLINIC	0.509711				90
90.01 SALEM MEDICAL CLINIC					90.01
91 EMERGENCY	0.838062				91
92 OBSERVATION BEDS	1.026742				92
OTHER REIMBURSABLE COST CENTERS					
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		216,578	105,926		200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES					201
202 NET CHARGES (LINE 200 MINUS LINE 201)		216,578			202

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
 PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
 08/27/2012 15:17

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

CHECK [ ] TITLE V [XX] HOSPITAL (14-1345) [ ] SUB (OTHER) [ ] S/B SNF [ ] PPS  
 APPLICABLE [ ] TITLE XVIII-PT A [ ] IPF [ ] SNF [ ] S/B NF [ ] TEFRA  
 BOXES [XX] TITLE XIX [ ] IRF [ ] NF [ ] ICF/MR [XX] OTHER

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS (COL.1 x COL.2) 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.772679			50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.229083			54
60 LABORATORY	0.271828			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.350243			65
66 PHYSICAL THERAPY	0.556637			66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.166534			69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.447949			71
73 DRUGS CHARGED TO PATIENTS	0.566222			73
76.97 CARDIAC REHABILITATION				76.97
76.98 HYPERBARIC OXYGEN THERAPY				76.98
76.99 LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS				
88 RURAL HEALTH CLINIC (RHC)				88
90 CLINIC	0.509711			90
90.01 SALEM MEDICAL CLINIC				90.01
91 EMERGENCY	0.838062			91
92 OBSERVATION BEDS	1.026742			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)				200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)				202



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [XX] HOSPITAL (14-1345) [ ] SUB (OTHER)  
 APPLICABLE [ ] IPF [ ] SNF  
 BOX: [ ] IRF [ ] SWING BED SNF

INPATIENT  
 PART A PART B

DESCRIPTION	MM/DD/YYYY		AMOUNT	
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,101,600		3,908,218
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
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 12/16/2011	130,682		3.01
	.02 06/10/2011	44,391	06/10/2011	3.02
PROGRAM .03				3.03
TO .04				3.04
PROVIDER .05				3.05
.06				3.06
.07				3.07
.08				3.08
.09				3.09
.50				3.50
.51 09/23/2011		35,617	09/23/2011	3.51
PROVIDER .52			12/16/2011	3.52
TO .53				3.53
PROGRAM .54				3.54
.55				3.55
.56				3.56
.57				3.57
.58				3.58
.59				3.59
.99				3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		139,456		-231,096
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		4,241,056		3,677,122

TO BE COMPLETED BY CONTRACTOR

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	NONE		NONE	5.01
	TO .02				5.02
	PROVIDER .03				5.03
	.04				5.04
	.05				5.05
	.06				5.06
	.07				5.07
	.08				5.08
	.09				5.09
	PROVIDER .50	NONE		NONE	5.50
	TO .51				5.51
	PROGRAM .52				5.52
	.53				5.53
	.54				5.54
	.55				5.55
	.56				5.56
	.57				5.57
	.58				5.58
	.59				5.59
	.99				5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)					
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01			291,538	6.01
	TO .02				
	PROVIDER .01				
	PROVIDER .02	-116,759			6.02
	TO .02				
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		4,124,297		3,968,660	7

8 NAME OF CONTRACTOR:

CONTRACTOR NUMBER:

DATE:

\_\_\_\_\_

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1  
 PART I

CHECK [ ] HOSPITAL  
 APPLICABLE [ ] IPF  
 BOX: [ ] IRF

[ ] SUB (OTHER)  
 [ ] SNF  
 [XX] SWING BED SNF (14-Z345)

INPATIENT  
 PART A

PART B

DESCRIPTION	MM/DD/YYYY		AMOUNT	
	1	2	3	4
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		304,117		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 12/16/2011	13,050		NONE 3.01
	.02 06/10/2011	8,857		3.02
PROGRAM	.03			3.03
TO	.04			3.04
PROVIDER	.05			3.05
	.06			3.06
	.07			3.07
	.08			3.08
	.09			3.09
	.50			3.50
	.51 09/23/2011	1,910		NONE 3.51
PROVIDER	.52			3.52
TO	.53			3.53
PROGRAM	.54			3.54
	.55			3.55
	.56			3.56
	.57			3.57
	.58			3.58
	.59			3.59
	.99			3.99
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		19,997		
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		324,114		4

TO BE COMPLETED BY CONTRACTOR

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	NONE		NONE 5.01
	TO .02			5.02
	PROVIDER .03			5.03
	.04			5.04
	.05			5.05
	.06			5.06
	.07			5.07
	.08			5.08
	.09			5.09
	PROVIDER .50	NONE		NONE 5.50
	TO .51			5.51
	PROGRAM .52			5.52
	.53			5.53
	.54			5.54
	.55			5.55
	.56			5.56
	.57			5.57
	.58			5.58
	.59			5.59
	.99			5.99
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)				
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT	PROGRAM .01	6,836		6.01
	TO .02			6.02
	PROVIDER			
	PROVIDER			
	TO .02			6.02
	PROGRAM			
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		330,950		7

8 NAME OF CONTRACTOR:

CONTRACTOR NUMBER:

DATE:

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
08/27/2012 15:17

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK  
APPLICABLE BOX

HOSPITAL (14-1345)       CAH

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	852 1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,533 2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	3 3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	3,084 4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	43,613,610 5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	450,782 6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	592,447 7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	592,447 8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30	INITIAL/INTERIM HIT PAYMENT(S)	578,643 30
31	OTHER ADJUSTMENTS (SPECIFY)	31 31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	13,804 32

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL  
PERIOD FROM 04/01/2011 TO 03/31/2012

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-10 (08/2011)

VERSION: 2011.10  
08/27/2012 15:17

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK [ ] TITLE V [XX] SWING BED - SNF (14-Z345)  
APPLICABLE [XX] TITLE XVIII [ ] SWING BED - NF  
BOXES [ ] TITLE XIX

COMPUTATION OF NET COST OF COVERED SERVICES

	PART A	PART B
	1	2
1 INPATIENT ROUTINE SERVICES - SWING BED-SNF (SEE INSTRUCTIONS)	226,855	1
2 INPATIENT ROUTINE SERVICES - SWING BED-NF (SEE INSTRUCTIONS)		2
3 ANCILLARY SERVICES (FROM WKST D-3, COL. 3, LINE 200 FOR PART A, AND SUM OF WKST D, PART V, COLS. 5 AND 7, LINE 202 FOR PART B) (FOR CAH, SEE INSTRUCTIONS)	106,985	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	201	5
6 INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		6
7 UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY		7
8 SUBTOTAL (SUM OF LINES 1-3 PLUS LINES 6 AND 7)	333,840	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	333,840	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	333,840	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)	2,890	13
14 80% OF PART B COSTS (LINE 12 x 80%)		14
15 SUBTOTAL (ENTER THE LESSER OF LINE 12 MINUS LINE 13, OR LINE 14)	330,950	15
16 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		16
17 REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		17
18 REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		18
19 TOTAL (SUM OF LINES 15 AND 17 PLUS/MINUS LINE 16)	330,950	19
20 INTERIM PAYMENTS	324,114	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	6,836	22
23 PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2		23

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART V

CHECK [XX] HOSPITAL (14-1345)  
 APPLICABLE BOX: [ ] SUB (OTHER)

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)

1	INPATIENT SERVICES	4,456,311	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	4,456,311	4
5	PRIMARY PAYER PAYMENTS	694	5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	4,500,180	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	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 (NOT TO EXCEED 1.000000)		13
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		14
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 14 EXCEEDS LINE 6) (SEE INSTR.)		15
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 6 EXCEEDS LINE 14) (SEE INSTR.)		16
17	COST OF TEACHING PHYSICIANS (FROM WKST D-5, PART II, COL. 3, LINE 20) (SEE INSTRUCTIONS)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4, LINE 49)		18
19	COST OF COVERED SERVICES (SUM OF LINES 6, 17 AND 18)	4,500,180	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	474,165	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	4,026,015	22
23	COINSURANCE	566	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	4,025,449	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	98,848	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	98,848	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	90,554	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	4,124,297	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	4,124,297	30
31	INTERIM PAYMENTS	4,241,056	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-116,759	33
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART VII

CHECK [ ] TITLE V [XX] HOSPITAL (14-1345) [ ] SNF [ ] PPS  
 APPLICABLE [XX] TITLE XIX [ ] IPF [ ] NF [ ] TEFRA  
 BOXES: [ ] IRF [ ] ICF/MR [XX] OTHER  
 [ ] SUB (OTHER)

PART VII - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	150,857	1
2	MEDICAL AND OTHER SERVICES		2
3	ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4	SUBTOTAL (SUM OF LINES 1, 2 AND 3)	150,857	4
5	INPATIENT PRIMARY PAYER PAYMENTS		5
6	OUTPATIENT PRIMARY PAYER PAYMENTS		6
7	SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	150,857	7
COMPUTATION OF LESSER OF COST OR CHARGES REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES		8
9	ANCILLARY SERVICE CHARGES		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE		10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION		11
12	TOTAL REASONABLE CHARGES (SUM OF LINES 8-11)		12
CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		13
14	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)		14
15	RATIO OF LINE 13 TO LINE 14 (NOT TO EXCEED 1.000000)		15
16	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (COMPLETE ONLY IF LINE 16 EXCEEDS LINE 4 (SEE INSTRUCTIONS))		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 4 EXCEEDS LINE 16 (SEE INSTRUCTIONS))		18
19	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		19
20	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		20
21	COST OF COVERED SERVICES (LESSER OF LINE 4 OR LINE 16) (FOR CAH, SEE INSTRUCTIONS)	150,857	21
PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS		22
23	OUTLIER PAYMENTS		23
24	PROGRAM CAPITAL PAYMENTS		24
25	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS		26
27	SUBTOTAL (SUM OF LINES 22 THROUGH 26)		27
28	CUSTOMARY CHARGES (TITLES V OR XIX PPS COVERED SERVICES ONLY)		28
29	SUM OF LINES 27 AND 21	150,857	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (FROM LINE 18)		30
31	SUBTOTAL (SUM OF LINES 19 AND 20 PLUS 29 MINUS LINES 5 AND 6)	150,857	31
32	DEDUCTIBLES		32
33	COINSURANCE		33
34	ALLOWABLE BAD DEBTS (SEE INSTRUCTIONS)		34
35	UTILIZATION REVIEW		35
36	SUBTOTAL (SUM OF LINES 31, 34 AND 35 MINUS THE SUM OF LINES 32 AND 33)	150,857	36
37	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38	SUBTOTAL (LINE 36 ± LINE 37)	150,857	38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (FROM WKST E-4)		39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (SUM OF LINES 38 AND 39)	150,857	40
41	INTERIM PAYMENTS		41
42	BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	150,857	42
43	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		43

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	2,402,941			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	5,850,710			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-1,954,956			6
7	INVENTORY	322,403			7
8	PREPAID EXPENSES	229,434			8
9	OTHER CURRENT ASSETS	327,976			9
10	DUE FROM OTHER FUNDS	133,838			10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	7,312,346			11
FIXED ASSETS					
12	LAND	61,162			12
13	LAND IMPROVEMENTS	913,078			13
14	ACCUMULATED DEPRECIATION	-590,913			14
15	BUILDINGS	23,943,954			15
16	ACCUMULATED DEPRECIATION	-6,527,186			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	1,898,294			19
20	ACCUMULATED DEPRECIATION	-873,722			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	9,639,668			23
24	ACCUMULATED DEPRECIATION	-6,644,380			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS				27
28	ACCUMULATED DEPRECIATION				28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	21,819,955			30
OTHER ASSETS					
31	INVESTMENTS	3,353,600			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	422,535			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	3,776,135			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	32,908,436			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	925,622			37
38	SALARIES, WAGES & FEES PAYABLE	990,296			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	130,000			40
41	DEFERRED INCOME				41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	450,501			43
44	OTHER CURRENT LIABILITIES	69,263			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	2,565,682			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	8,080,000			46
47	NOTES PAYABLE				47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	8,080,000			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	10,645,682			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	22,262,754			52
53	SPECIFIC PURPOSE FUND BALANCE				53
54	DONOR CREATED-ENDOWMENT FUND BAL-RESTRICTED				54
55	DONOR CREATED-ENDOWMENT FUND BAL-UNRESTRICTED				55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BAL				56
57	PLANT FUND BALANCE - INVESTED IN PLANT				57
58	PLANT FUND BALANCE - RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				58
59	TOTAL FUND BALANCES (SUM OF LINES 52-58)	22,262,754			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	32,908,436			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4	ENDOWMENT FUND 5	6	PLANT FUND 7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		21,413,054							1
2 NET INCOME (LOSS) (FROM WKST G-3, G-3, LINE 29)		849,700							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		22,262,754							3
4 ADDITIONS (CREDIT ADJUSTMENTS)									4
5									5
6									6
7									7
8									8
9									9
10 TOTAL ADDITIONS (SUM OF LINES 4-9)									10
11 SUBTOTAL (LINE 3 PLUS LINE 10)		22,262,754							11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)									12
13									13
14									14
15									15
16									16
17									17
18 TOTAL DEDUCTIONS (SUM OF LINES 12-17)									18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (LINE 11 MINUS LINE 18)		22,262,754							19

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				1
2 HOSPITAL	2,310,941		2,310,941	2
3 SUBPROVIDER IPF				3
5 SUBPROVIDER IRF				5
6 SWING BED - SNF	56,645		56,645	6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,367,586		2,367,586	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	269,602		269,602	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
17 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	269,602		269,602	17
18 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,637,188		2,637,188	18
19 ANCILLARY SERVICES	6,058,528		6,058,528	19
20 OUTPATIENT SERVICES		36,766,866	36,766,866	20
21 RHC		597,827	597,827	21
22 FQHC				22
23 HOME HEALTH AGENCY				23
25 AMBULANCE				25
26 ASC				26
27 HOSPICE				27
28 OTHER (SPECIFY)				28
TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	8,695,716	37,364,693	46,060,409	

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		24,259,698	29
30 ADD (SPECIFY)			30
31			31
32			32
33			33
34			34
35			35
36 TOTAL ADDITIONS (SUM OF LINES 30-35)			36
37 DEDUCT (SPECIFY)			37
38			38
39			39
40			40
41			41
42 TOTAL DEDUCTIONS (SUM OF LINES 37-41)			42
43 TOTAL OPERATING EXPENSES (SUM OF LINES 29 AND 36 MINUS LINE 42) (TRANSFER TO WKST G-3, LINE 4)		24,259,698	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	46,060,409	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	21,614,318	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	24,446,091	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	24,259,698	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	186,393	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	9,841	7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	640	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	146,531	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	25	18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	56,079	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PROPERTY TAX REVENUE)	238,030	24
24.01	OTHER (OTHER OPERATING INCOME (EXPENSE))	186,248	24.01
24.02	OTHER (NONCAPITAL GRANTS AND CONTRIBUTIONS)	32,431	24.02
24.03	OTHER (CAPITAL GRANTS AND CONTRIBUTIONS)	12,333	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	682,158	25
26	TOTAL (LINE 5 PLUS LINE 25)	868,551	26
27	OTHER EXPENSES (LOSS ON DISPOSITION OF EQUIPMENT)	18,851	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	18,851	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	849,700	29

ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (COLS.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL
	0	2A	24	25	26
GENERAL SERVICE COST CENTERS					
1 CAP REL COSTS-BLDG & FIXT					1
2 CAP REL COSTS-MVBLE EQUIP					2
4 EMPLOYEE BENEFITS					4
5.01 ADMINISTRATIVE & ACCOUNTING					5.01
5.02 BUSINESS SERVICES					5.02
6 MAINTENANCE & REPAIRS					6
7 OPERATION OF PLANT					7
8 LAUNDRY & LINEN SERVICE					8
9 HOUSEKEEPING					9
10 DIETARY					10
11 CAFETERIA					11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION					13
14 CENTRAL SERVICES & SUPPLY					14
14.01 PURCHASING					14.01
14.02 CENTRAL SERVICES & SUPPLY					14.02
15 PHARMACY					15
16 MEDICAL RECORDS & LIBRARY					16
17 SOCIAL SERVICE					17
19 NONPHYSICIAN ANESTHETISTS					19
20 NURSING SCHOOL					20
21 I&R SRVCES-SALARY & FRINGES AP					21
22 I&R SRVCES-OTHER PRGM COSTS AP					22
23 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS					30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM					50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC					54
60 LABORATORY					60
62.30 BLOOD CLOTTING FOR HEMOPHILIAC					62.30
65 RESPIRATORY THERAPY					65
66 PHYSICAL THERAPY					66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY					69
71 MEDICAL SUPPLIES CHRGD TO PAT					71
73 DRUGS CHARGED TO PATIENTS					73
76.97 CARDIAC REHABILITATION					76.97
76.98 HYPERBARIC OXYGEN THERAPY					76.98
76.99 LITHOTRIPSY					76.99
88 RURAL HEALTH CLINIC (RHC)					88
OUTPATIENT SERVICE COST CENTERS					
90 CLINIC					90
90.01 SALEM MEDICAL CLINIC					90.01
91 EMERGENCY					91
92 OBSERVATION BEDS					92
OTHER REIMBURSABLE COST CENTERS					
99.10 CORF					99.10
99.20 OUTPATIENT PHYSICAL THERAPY					99.20
99.30 OUTPATIENT OCCUPATIONAL THERAP					99.30
99.40 OUTPATIENT SPEECH PATHOLOGY					99.40
SPECIAL PURPOSE COST CENTERS					
118 SUBTOTALS (SUM OF LINES 1-117)					118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CA					190
192 PHYSICIANS' PRIVATE OFFICES					192
192.01 TEMPORARILY IDLE SPACE					192.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINE 118 AND LINES 190-201)					202
203 TOTAL STATISTICAL BASIS					203
204 UNIT COST MULTIPLIER					204
204 UNIT COST MULTIPLIER					204

RHC I  
 COMPONENT NO: 14-3413

WORKSHEET M-1

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

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

	COMPEN- SATION 1	OTHER COSTS 2	TOTAL (COL.1 + COL.2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (COL.3+4) 5	ADJUST- MENTS 6	NET EXPENSES FOR ALLOCATION (COL.5+6) 7	
FACILITY HEALTH CARE STAFF COSTS								
1 PHYSICIAN								1
2 PHYSICIAN ASSISTANT								2
3 NURSE PRACTITIONER	166,666	12,584	179,250		179,250		179,250	3
4 VISITING NURSE								4
5 OTHER NURSE	106,601	8,049	114,650		114,650		114,650	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)	273,267	20,633	293,900		293,900		293,900	10
COSTS UNDER AGREEMENT								
11 PHYSICIAN SERVICES UNDER AGREEMENT				91,391	91,391		91,391	11
12 PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13 OTHER COSTS UNDER AGREEMENT								13
14 SUBTOTAL (SUM OF LINES 11-13)				91,391	91,391		91,391	14
OTHER HEALTH CARE COSTS								
15 MEDICAL SUPPLIES		8,809	8,809		8,809		8,809	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)		8,809	8,809		8,809		8,809	21
22 TOTAL COSTS OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	273,267	29,442	302,709	91,391	394,100		394,100	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 (SUM OF LINES 23-27)								28
FACILITY OVERHEAD								
29 FACILITY COSTS								29
30 ADMINISTRATIVE COSTS	84,612	8,347	92,959		92,959		92,959	30
31 TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	84,612	8,347	92,959		92,959		92,959	31
32 TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	357,879	37,789	395,668	91,391	487,059		487,059	32

RHC I  
 COMPONENT NO: 14-3413

WORKSHEET M-2

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

CHECK APPLICABLE BOX [ XX ] RHC [ ] FQHC

VISITS AND PRODUCTIVITY

	NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD	MINIMUM VISITS (COL.1 x COL.3)	GREATER OF COL. 2 OR COL. 4	
	1	2	3	4	5	
1	PHYSICIANS		4,200			1
2	PHYSICIAN ASSISTANTS		2,100			2
3	NURSE PRACTITIONERS	1.93	5,000	2,100	4,053	3
4	SUBTOTAL (SUM OF LINES 1-3)	1.93	5,000		4,053	5,000
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.93	5,000			5,000
9	PHYSICIAN SERVICES UNDER AGREEMENTS		375			375

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				394,100	10
11	TOTAL NONREIMBURSABLE COSTS (FROM WKST M-1, COL. 7, LINE 28)					11
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)				394,100	12
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)				1.000000	13
14	TOTAL FACILITY OVERHEAD (FROM WKST M-1, COL. 7, LINE 31)				92,959	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				266,818	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				359,777	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				359,777	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				359,777	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				753,877	20

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES  
 RHC I COMPONENT NO: 14-3413

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WKST M-2, LINE 20)	753,877	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	2,913	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	750,964	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	5,000	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)	375	5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	5,375	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	139.71	7

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

8	PER VISIT PAYMENT LIMIT (FROM CMS PUB 27, SEC. 505 OR YOUR CONTRACTOR)			8
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	139.71	139.71	139.71 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	536	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	74,885	11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)		12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (LINE 9 x LINE 12)		13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (SEE INSTRUCTIONS)		14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (SEE INSTRUCTIONS)		15
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLS. 1, 2, AND 3)	74,885	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS)(FROM CONTRACTOR'S RECORDS)	67,618	16.01
16.02	TOTAL PROGRAM PREVENTIVE CHARGES (SEE INSTRUCTIONS)(FROM PROVIDER'S RECORDS)		16.02
16.03	TOTAL PROGRAM PREVENTIVE COSTS ((LINE 16.02/LINE 16.01) TIMES LINE 16)		16.03
16.04	TOTAL PROGRAM NON-PREVENTIVE COSTS ((LINE 16 MINUS LINE 16.03) TIMES 80%)	50,530	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	50,530	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS)(FROM CONTRACTOR RECORDS)	11,723	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)		19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	50,530	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	2,913	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	53,443	22
23	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		23
24	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		24
25	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		25
26	NET REIMBURSABLE AMOUNT (LINES 22 PLUS 23 PLUS OR MINUS LINE 25)	53,443	26
27	INTERIM PAYMENTS	72,011	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	-18,568	29
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, CHAPTER I, SECTION 115.2		30

(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 [ ] TITLE XIX  
 APPLICABLE BOXES: [ ] FQHC [ XX ] TITLE XVIII

	PNEUMOCOCCAL 1	SEASONAL INFLUENZA 2	
1 HEALTH CARE STAFF COST (FROM WKST M-1, COL. 7, LINE 10)	293,900	293,900	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.001198	0.001198	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	352	352	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	181	638	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	533	990	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	394,100	394,100	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	359,777	359,777	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001352	0.002512	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	486	904	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,019	1,894	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	3	57	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10 / LINE 11)	339.67	33.23	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	3	57	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,019	1,894	14
15 TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 10) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 2)		2,913	15
16 TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (SUM OF COLS. 1 AND 2, LINE 14) (TRANSFER THIS AMOUNT TO WKST M-3, LINE 21)		2,913	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 APPLICABLE BOX [ XX ] RHC [ ] FQHC

DESCRIPTION	PART B		
	1 MM/DD/YYYY	2 AMOUNT	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		65,655	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 09/23/2011	6,356	3.01
	.02		3.02
	PROGRAM .03		3.03
	TO .04		3.04
	PROVIDER .05		3.05
	.06		3.06
	.07		3.07
	.08		3.08
	.09		3.09
	.50	NONE	3.50
	.51		3.51
	PROVIDER .52		3.52
	TO .53		3.53
	PROGRAM .54		3.54
	.55		3.55
	.56		3.56
	.57		3.57
	.58		3.58
	.59		3.59
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)	.99	6,356	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		72,011	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	NONE	5.01
	TO .02		5.02
	PROVIDER .03		5.03
	.04		5.04
	.05		5.05
	.06		5.06
	.07		5.07
	.08		5.08
	.09		5.09
	PROVIDER .50	NONE	5.50
	TO .51		5.51
	PROGRAM .52		5.52
	.53		5.53
	.54		5.54
	.55		5.55
	.56		5.56
	.57		5.57
	.58		5.58
	.59		5.59
SUBTOTAL (SUM OF LINES 5.01-5.49 MINUS SUM OF LINES 5.50-5.98)	.99		5.99
6 DETERMINE NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT (SEE INSTR.	PROGRAM TO .01		6.01
	PROVIDER PROVIDER TO .02	-18,568	6.02
	PROGRAM		
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		53,443	7
8 NAME OF CONTRACTOR: _____	CONTRACTOR NUMBER: _____	DATE: _____	

\*\*\*\*\* 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							
30 ADULTS & PEDIATRICS	79.18		4.22				83.40 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	8.49	44.32					52.81 50
54 RADIOLOGY-DIAGNOSTIC	5.76	37.92					43.68 54
60 LABORATORY	10.59	32.85					43.44 60
65 RESPIRATORY THERAPY	37.11	22.99					60.10 65
66 PHYSICAL THERAPY	3.80	37.23					41.03 66
69 ELECTROCARDIOLOGY	5.36	51.41					56.77 69
71 MEDICAL SUPPLIES CHRGED TO PATI	18.22	32.36					50.58 71
73 DRUGS CHARGED TO PATIENTS	31.31	37.82					69.13 73
90 CLINIC		49.91					49.91 90
91 EMERGENCY	0.11	35.76					35.87 91
92 OBSERVATION BEDS		64.02					64.02 92
200 TOTAL CHARGES	10.44	35.59					46.03 200

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

SWING-BED SNF / NF

COST CENTERS	---- TITLE XVIII ----		----- TITLE XIX -----		----- TITLE V -----		TOTAL THIRD	
	PART A 1	PART B 2	INPATIENT 3	OUTPATIENT 4	INPATIENT 5	OUTPATIENT 6	PARTY UTIL 7	
UTILIZATION PERCENTAGES BASED ON CHARGES								
54	RADIOLOGY-DIAGNOSTIC	0.02					0.02	54
60	LABORATORY	0.26					0.26	60
65	RESPIRATORY THERAPY	0.70					0.70	65
66	PHYSICAL THERAPY	4.50					4.50	66
69	ELECTROCARDIOLOGY	0.04					0.04	69
71	MEDICAL SUPPLIES CHRGED TO PATI	1.58					1.58	71
73	DRUGS CHARGED TO PATIENTS	1.71					1.71	73
200	TOTAL CHARGES	0.53					0.53	200

COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
	AMOUNT	%	AMOUNT	%	AMOUNT	%	
GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,707,007	8.27	-1,707,007	-15.93		1
2	CAP REL COSTS-MVBLE EQUIP	1,482,502	7.18	-1,482,502	-13.83		2
3	OTHER CAPITAL RELATED COSTS						3
4	EMPLOYEE BENEFITS	1,877,562	9.10	-1,877,562	-17.52		4
5.01	ADMINISTRATIVE & ACCOUNTING	1,132,679	5.49	-1,132,679	-10.57		5.01
5.02	BUSINESS SERVICES	1,068,106	5.17	-1,068,106	-9.97		5.02
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT	891,042	4.32	-891,042	-8.31		7
8	LAUNDRY & LINEN SERVICE	61,259	0.30	-61,259	-0.57		8
9	HOUSEKEEPING	212,831	1.03	-212,831	-1.99		9
10	DIETARY	142,865	0.69	-142,865	-1.33		10
11	CAFETERIA	361,629	1.75	-361,629	-3.37		11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION	66,792	0.32	-66,792	-0.62		13
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING	96,443	0.47	-96,443	-0.90		14.01
14.02	CENTRAL SERVICES & SUPPLY						14.02
15	PHARMACY	1,168,182	5.66	-1,168,182	-10.90		15
16	MEDICAL RECORDS & LIBRARY	394,201	1.91	-394,201	-3.68		16
17	SOCIAL SERVICE	54,455	0.26	-54,455	-0.51		17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SRVCES-SALARY & FRINGES APP						21
22	I&R SRVCES-OTHER PRGM COSTS APP						22
23	PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,784,671	8.65	2,014,685	18.80	3,799,356	18.41
31	INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	902,483	4.37	1,074,269	10.02	1,976,752	9.58
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	1,276,256	6.18	1,890,843	17.64	3,167,099	15.34
60	LABORATORY	1,400,902	6.79	1,367,052	12.76	2,767,954	13.41
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	438,664	2.13	445,514	4.16	884,178	4.28
66	PHYSICAL THERAPY	755,291	3.66	457,482	4.27	1,212,773	5.88
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	48,575	0.24	70,152	0.65	118,727	0.58
71	MEDICAL SUPPLIES CHRGD TO PATI	621,290	3.01	188,168	1.76	809,458	3.92
73	DRUGS CHARGED TO PATIENTS			1,440,929	13.44	1,440,929	6.98
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
88	RURAL HEALTH CLINIC (RHC)	487,059	2.36	266,818	2.49	753,877	3.65
90	CLINIC	157,303	0.76	110,153	1.03	267,456	1.30
90.01	SALEM MEDICAL CLINIC						90.01
91	EMERGENCY	1,904,172	9.23	940,955	8.78	2,845,127	13.78
92	OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS							
OUTPATIENT SERVICE COST CENTERS							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS							
NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CAN	100,289	0.49	78,615	0.73	178,904	0.87
192	PHYSICIANS' PRIVATE OFFICES	45,720	0.22	135,705	1.27	181,425	0.88
192.01	TEMPORARILY IDLE SPACE			236,215	2.20	236,215	1.14
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL	20,640,230	100.00			20,640,230	100.00

\*\*\*\* 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, 2.02 x COLUMN 1  
LESS LINES 61, 66-68, 74, 94, 95 & 96)
  
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES  
EXCLUDING SERVICES NOT SUBJECT TO OPPTS.  
(WKST D, PART V, LINE 202, COLUMNS 2, 2.01,  
& 2.02 LESS LINES 61, 66-68, 74, 94, 95 &  
96)
  
3. RATIO OF COST TO CHARGES (LINE 1 / LINE 2)