

SALEM TOWNSHIP HOSPITAL

SALEM, ILLINOIS

MEDICARE ANALYSIS

FOR THE YEAR ENDED MARCH 31, 2013

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: 08/27/2013 TIME: 09:06
 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 5. COST REPORT STATUS 6. DATE RECEIVED: _____ 10. NPR DATE: _____
 USE ONLY 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 04/01/2012 AND ENDING 03/31/2013, 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, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 08/27/2013 09:06
 eV5OwB9YNG5igfA3.Gom3IEPdMtpI0
 sdamf0CZKomo0gtGIRGnmWHwN0ncz9
 WYsr0inbqX0Z5MrW

(SIGNED)

 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

 TITLE

 DATE

PI Encryption: 08/27/2013 09:06
 YPevHQjsUESwszfbXGqFaoD0d4vwi0
 ptPVc0b8WUDU931Q7iEMoaxTd4gqWKS
 x1VP0z:AQb0DL.fr
 PART III - SETTLEMENT SUMMARY

	TITLE V 1	TITLE XVIII		HIT 4	TITLE XIX 5	
		PART A 2	PART B 3			
1 HOSPITAL		-788,453	121,856	493,341	181,133	1
2 SUBPROVIDER - IPF						2
3 SUBPROVIDER - IRF						3
4 SUBPROVIDER (OTHER)						4
5 SWING BED - SNF		4,525				5
6 SWING BED - NF						6
7 SKILLED NURSING FACILITY						7
8 NURSING FACILITY						8
9 HOME HEALTH AGENCY						9
10 HEALTH CLINIC - RHC			-9,293			10
11 HEALTH CLINIC - FQHC						11
12 OUTPATIENT REHABILITATION PROVIDER						12
200 TOTAL		-783,928	112,563	493,341	181,133	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:

PAYMENT SYSTEM
 (P, T, O, OR N)
 V XVIII XIX
 6 7 8

0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
COMPONENT	NAME	CCN NUMBER	CBSA NUMBER	PROV TYPE	DATE CERTIFIED	P	T	O	N												
3	HOSPITAL	14-1345	16460	1	07/01/1966	N	O	O													
4	SUBPROVIDER - IPF																				
5	SUBPROVIDER - IRF																				
6	SUBPROVIDER - (OTHER)																				
7	SWING BEDS - SNF	14-2345	16460		12/17/1986	N	O	N													
8	SWING BEDS - NF																				
9	HOSPITAL-BASED SNF																				
10	HOSPITAL-BASED NF																				
11	HOSPITAL-BASED OLT																				
12	HOSPITAL-BASED HHA	14-7429	16460		08/01/1985	N	P	N													
13	SEPARATELY CERTIFIED ASC																				
14	HOSPITAL-BASED HOSPICE																				
15	HOSPITAL-BASED HEALTH CLINIC - RHC	14-3413	16460		07/29/1996	N	O	N													
16	HOSPITAL-BASED HEALTH CLINIC - FQHC																				
17	HOSPITAL-BASED (CMHC)																				
18	RENAL DIALYSIS																				
19	OTHER																				
20	COST REPORTING PERIOD (MM/DD/YYYY)	FROM: 04/01/2012			TO: 03/31/2013																
21	TYPE OF CONTROL				12																

INPATIENT PPS INFORMATION

22	23	1	2
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	25	26	27	35	36	37	38
IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF-STATE MEDICAID PAID DAYS	OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS	OTHER MEDICAID DAYS		
1	2	3	4	5	6		
24	IF THIS PROVIDER IS AN IPHS HOSPITAL, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID DAYS IN COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.						24
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, IN-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 2, OUT-OF-STATE MEDICAID PAID DAYS IN COL. 3, OUT-OF-STATE MEDICAID ELIGIBLE UNPAID DAYS IN COL. 4, MEDICAID HMO PAID AND ELIGIBLE BUT UNPAID 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 IN COLUMN 1, '1' FOR URBAN OR '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

39	1	2	
39	DOES THE FACILITY POTENTIALLY QUALIFY FOR THE INPATIENT HOSPITAL ADJUSTMENT FOR LOW VOLUME HOSPITALS AS DEEMED BY CMS ACCORDING TO THE FEDERAL REGISTER? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. ADDITIONALLY, DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (SEE INSTRUCTIONS)	N	N 39

PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL

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

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

		1	2	3	
TEACHING HOSPITALS					
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
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)	Y/N N	IME AVERAGE	DIRECT GME AVERAGE	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
SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.					
64	ENTER IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, 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)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	64
ENTER IN LINES 65-65.49 IN COLUMN 1, IF LINE 63 IS YES, OR YOUR FACILITY TRAINED RESIDENTS IN THE BASE YEAR PERIOD, 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 EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010					
66	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)	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (COL.1/ (COL.1+COL.2))	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		
INPATIENT PSYCHIATRIC FACILITY PPS						
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		
INPATIENT REHABILITATION FACILITY PPS						
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		
LONG TERM CARE HOSPITAL PPS						
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.			N 80		
TEFRA PROVIDERS						
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		
TITLE V AND XIX INPATIENT SERVICES						
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.			N 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 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 93		
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.			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 96		
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97		
RURAL PROVIDERS						
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?			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 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- Y	OCCUP- Y	RESPI- SICAL Y	ATIONAL N	SPEECH RATORY 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. IF COLUMN 2 IS 'E', ENTER IN COLUMN 3 EITHER '93' PERCENT FOR SHORT TERM HOSPITAL OR '98' PERCENT FOR LONG TERM CARE (INCLUDES PSYCHIATRIC, REHABILITATION AND LONG TERM HOSPITALS PROVIDERS) BASED ON THE DEFINITION IN CMS 15-1§ 2208.1.	N		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: 187,824 PAID LOSSES: SELF INSURANCE:			118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER 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 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THIS A RURAL HOSPITAL WITH < 100 BEDS THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA §3121 AND APPLICABLE AMENDMENTS? (SEE INSTRUCTIONS). 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.	Y		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.	1 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, LINE 74 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
155	HOSPITAL	1	2	3	4
156	SUBPROVIDER - IPF	N	N	N	155
157	SUBPROVIDER - IRF	N	N	N	156
158	SUBPROVIDER - (OTHER)	N	N	N	157
159	SNF	N	N	N	158
160	HHA	N	N	N	159
161	CMHC	N	N	N	160

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
 PART I (CONT)

MULTICAMPUS

165 IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? N 165
 ENTER 'Y' FOR YES OR 'N' FOR NO.

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'), 1,079,270 168
 ENTER THE REASONABLE COST INCURRED FOR THE HIT ASSETS.
 169 IF THIS PROVIDER IS A MEANINGFUL USER (LINE 167 IS 'Y') AND IS NOT A CAH 169
 (LINE 105 IS 'N'), ENTER THE TRANSITIONAL FACTOR.

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

PROVIDER ORGANIZATION AND OPERATION		Y/N	DATE			
1		1	2			
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)	N		1		
		Y/N	DATE	V/I		
2		1	2	3		
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.	N		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		
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE		
4		1	2	3		
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.	Y	A	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		
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N		
6		1		2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		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		
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		
15	BED COMPLEMENT DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N 15		
PS&R REPORT DATA		PART A		PART B		
16		Y/N	DATE	Y/N	DATE	
17		1	2	3	4	
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)	N		N		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	07/23/2013	Y	07/23/2013	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: RECLASS OF MED SUPPLIES, CT, AND MR	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 RELIEF 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.	Y	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
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.	N	36
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	38
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		39
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		40

COST REPORT PREPARER CONTACT INFORMATION

41	FIRST NAME: MARK	LAST NAME: DALLAS	TITLE: PARTNER	41
42	EMPLOYER: KERBER, ECK & BRAECKEL, LLP			42
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: MDALLAS@KEBCPA.COM		43

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I

LINE NO.	COMPONENT	WKST A LINE NO.	NO OF BEDS 2	BED DAYS AVAILABLE 3	CAH HOURS 4	INPATIENT DAYS / OUTPATIENT VISITS / TRIPS			TOTAL ALL PATIENTS 8
						TITLE V 5	TITLE XVIII 6	TITLE XIX 7	
1	HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	25	9,125	63,528.00		2,056	156	2,647
2	HMO						12		2
3	HMO IPF SUBPROVIDER								3
4	HMO IRF SUBPROVIDER								4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						255		255
6	HOSPITAL ADULTS & PEDS. SWING BED NF								6
7	TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)		25	9,125	63,528.00		2,311	156	2,902
8	INTENSIVE CARE UNIT	31							8
9	CORONARY CARE UNIT	32							9
10	BURN INTENSIVE CARE UNIT	33							10
11	SURGICAL INTENSIVE CARE UNIT	34							11
12	OTHER SPECIAL CARE (SPECIFY)	35							12
13	NURSERY	43							13
14	TOTAL (SEE INSTRUCTIONS)		25	9,125	63,528.00		2,311	156	2,902
15	CAH VISITS								15
16	SUBPROVIDER - IPF	40							16
17	SUBPROVIDER - IRF	41							17
18	SUBPROVIDER I	42							18
19	SKILLED NURSING FACILITY	44							19
20	NURSING FACILITY	45							20
21	OTHER LONG TERM CARE	46							21
22	HOME HEALTH AGENCY	101							22
23	ASC (DISTINCT PART)	115							23
24	HOSPICE (DISTINCT PART)	116							24
25	CMHC	99							25
26	RHC	88					677		7,313
27	TOTAL (SUM OF LINES 14-26)		25						27
28	OBSERVATION BED DAYS								274
29	AMBULANCE TRIPS								29
30	EMPLOYEE DISCOUNT DAYS (SEE INSTR.)								30
31	EMPLOYEE DISCOUNT DAYS-IRF								31
32	LABOR & DELIVERY DAYS (SEE INSTR.)								32
33	LTCH NON-COVERED DAYS								33

HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
 PART I
 (CONTINUED)

COMPONENT	WKST A LINE NO.	--- FULL TIME EQUIVALENTS ---			----- DISCHARGES -----				
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15	
1 HOSPITAL ADULTS & PEDS. (COLS. 5, 6, 7 AND 8 EXCLUDE SWING BED, OBSERVATION BED AND HOSPICE DAYS)	30	9	10	11		528	62	746	1
2 HMO						4			2
3 HMO IPF									3
4 HMO IRF									4
5 HOSPITAL ADULTS & PEDS. SWING BED SNF									5
6 HOSPITAL ADULTS & PEDS. SWING BED NF									6
7 TOTAL ADULTS & PEDS. (EXCLUDE OBSERVATION BEDS) (SEE INSTR.)									7
8 INTENSIVE CARE UNIT	31								8
9 CORONARY CARE UNIT	32								9
10 BURN INTENSIVE CARE UNIT	33								10
11 SURGICAL INTENSIVE CARE UNIT	34								11
12 OTHER SPECIAL CARE (SPECIFY)	35								12
13 NURSERY	43								13
14 TOTAL (SEE INSTRUCTIONS)			169.45			528	62	746	14
15 CAH VISITS									15
16 SUBPROVIDER - IPF	40								16
17 SUBPROVIDER - IRF	41								17
18 SUBPROVIDER I	42								18
19 SKILLED NURSING FACILITY	44								19
20 NURSING FACILITY	45								20
21 OTHER LONG TERM CARE	46								21
22 HOME HEALTH AGENCY	101								22
23 ASC (DISTINCT PART)	115								23
24 HOSPICE (DISTINCT PART)	116								24
25 CMHC	99								25
26 RHC	88								26
27 TOTAL (SUM OF LINES 14-26)			177.81	8.36					27
28 OBSERVATION BED DAYS									28
29 AMBULANCE TRIPS									29
30 EMPLOYEE DISCOUNT DAYS (SEE INSTR.)									30
31 EMPLOYEE DISCOUNT DAYS-IRF									31
32 LABOR & DELIVERY DAYS (SEE INSTR.)									32
33 LTCH NON-COVERED DAYS									33

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	200					1
2						2
3						3
4						4
4.01						4.01
5						5
6						6
7	21					7
7.01						7.01
8						8
9	44					9
10						10
OTHER WAGES & RELATED COSTS						
11						11
12						12
13						13
14						14
15						15
16						16
WAGE-RELATED COSTS						
17						17
18						18
19						19
EXCLUDED AREAS						
20						20
21						21
22						22
22.01						22.01
23						23
24						24
25						25
OVERHEAD COSTS - DIRECT SALARIES						
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36						36
37						37
38						38
39						39
40						40
41						41
42						42
43						43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (SEE INSTRUCTIONS)	1
2	EXCLUDED AREA SALARIES (SEE INSTRUCTIONS)	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	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)	6
7	TOTAL OVERHEAD COST (SEE INSTRUCTIONS)	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 NONQUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	3
4 QUALIFIED DEFINED BENEFIT PLAN COST (SEE INSTRUCTIONS)	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 (OTHER THAN RETIREMENT COST REPORTED ON LINES 1 THROUGH 4 ABOVE) (SEE INSTRUCTIONS)	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 04/01/2012 TO 03/31/2013

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

VERSION: 2012.11
 08/21/2013 13:59

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

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

VERSION: 2012.11
 08/21/2013 13:59

WORKSHEET S-8

RHC I
 COMPONENT NO: 14-3413

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? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.		1 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
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 N	12
13 IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS IN THIS COST REPORT. LIST THE NAMES OF ALL PROVIDERS AND NUMBERS BELOW.		N	13
14 PROVIDER NAME:	CCN NUMBER:		14
15 HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (SEE INSTRUCTIONS)	Y/N N	V XVIII XIX TOTAL	15

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 202, COL. 3 DIVIDED BY LINE 202, COL. 8)				0.457118	1
MEDICAID (SEE INSTRUCTIONS FOR EACH LINE)						
2	NET REVENUE FROM MEDICAID				1,226,510	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				630,167	5
6	MEDICAID CHARGES				5,952,506	6
7	MEDICAID COST (LINE 1 TIMES LINE 6)				2,720,998	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (LINE 7 MINUS THE SUM OF LINES 2 AND 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.				864,321	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) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.					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) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.					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)				864,321	19
		UNINSURED PATIENTS	INSURED 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	377,042	267,272	644,314		20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (LINE 1 TIMES LINE 20)	172,353	122,175	294,528		21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	2,454	50,112	52,566		22
23	COST OF CHARITY CARE	169,899	72,063	241,962		23
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)			939,781		26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (SEE INSTRUCTIONS) WORKSHEET E-3, PART V			644,365		27
28	NON-MEDICARE AND NON-REIMBURSABLE BAD DEBT EXPENSE (LINE 26 MINUS LINE 27)			295,416		28
29	COST OF NON-MEDICARE BAD DEBT EXPENSE (LINE 1 TIMES LINE 28)			135,040		29
30	COST OF NON-MEDICARE UNCOMPENSATED CARE (LINE 23, COL. 3 PLUS LINE 29)			377,002		30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (LINE 19 PLUS LINE 30)			1,241,323		31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES 1	OTHER 2	TOTAL (COL. 1 + COL. 2) 3	RECLASSIFI- CATIONS 4	
GENERAL SERVICE COST CENTERS						
1	00100		1,190,206	1,190,206	467,983	1
2	00200		856,140	856,140	791,903	2
3	00300					3
4	00400	106,332	1,759,775	1,866,107		4
5.01	00592	590,727	3,480,507	4,071,234	-479,349	5.01
5.02	00591	608,021	583,457	1,191,478		5.02
6	00600					6
7	00700	210,336	546,300	756,636	-4,833	7
8	00800	29,691	19,334	49,025		8
9	00900	131,511	75,663	207,174		9
10	01000	248,978	387,606	636,584	-462,149	10
11	01100				461,203	11
12	01200					12
13	01300	69,867	20,626	90,493		13
14	01400					14
14.01	01401	85,752	16,618	102,370		14.01
14.02	01402	14,943	580,307	595,250	-595,149	14.02
15	01500	44,087	1,139,478	1,183,565		15
16	01600	143,682	136,808	280,490	-1,841	16
17	01700	58,292	8,972	67,264		17
19	01900				474,804	19
20	02000					20
21	02100					21
22	02200					22
23	02300					23
INPATIENT ROUTINE SERV COST CENTERS						
30	03000	1,574,374	279,735	1,854,109	-20,431	30
31	03100					31
ANCILLARY SERVICE COST CENTERS						
50	05000	595,745	439,668	1,035,413	-117,758	50
53	05300	33,500	469,071	502,571	-502,571	53
54	05400	551,296	409,452	960,748	-48,623	54
57	05700	77,648	165,778	243,426		57
58	05800	79,500	466,169	545,669	-454,890	58
60	06000	572,907	977,563	1,550,470	-65,732	60
62.30	06250					62.30
65	06500	300,912	209,314	510,226	-12,390	65
66	06600		728,097	728,097	-942	66
67	06700					67
68	06800					68
69	06900	39,791	53,008	92,799		69
71	07100				595,149	71
72	07200		21,817	21,817		72
73	07300					73
76.97	07697					76.97
76.98	07698					76.98
76.99	07699					76.99
OUTPATIENT SERVICE COST CENTERS						
88	08800	438,355	57,477	495,832	29,293	88
90	09000	132,734	26,210	158,944	-3,163	90
90.01	09001					90.01
91	09100	877,632	2,065,659	2,943,291	-48,016	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		7,616,613	17,170,815	24,787,428	2,498	118
NONREIMBURSABLE COST CENTERS						
190	19000	47,954	58,456	106,410		190
192	19200	99,019	66,360	165,379	-2,498	192
192.01	19201					192.01
200		7,763,586	17,295,631	25,059,217		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	1,658,189		1,658,189	1
2	00200	CAP REL COSTS-MVBLE EQUIP	1,648,043	-278,715	1,369,328	2
3	00300	OTHER CAPITAL RELATED COSTS				3
4	00400	EMPLOYEE BENEFITS	1,866,107	-61,103	1,805,004	4
5.01	00592	ADMINISTRATIVE & ACCOUNTING	3,591,885	-2,455,517	1,136,368	5.01
5.02	00591	BUSINESS SERVICES	1,191,478	-26,730	1,164,748	5.02
6	00600	MAINTENANCE & REPAIRS				6
7	00700	OPERATION OF PLANT	751,803		751,803	7
8	00800	LAUNDRY & LINEN SERVICE	49,025		49,025	8
9	00900	HOUSEKEEPING	207,174		207,174	9
10	01000	DIETARY	174,435	-29,324	145,111	10
11	01100	CAFETERIA	461,203	-102,439	358,764	11
12	01200	MAINTENANCE OF PERSONNEL				12
13	01300	NURSING ADMINISTRATION	90,493		90,493	13
14	01400	CENTRAL SERVICES & SUPPLY				14
14.01	01401	PURCHASING	102,370		102,370	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	101		101	14.02
15	01500	PHARMACY	1,183,565	-598	1,182,967	15
16	01600	MEDICAL RECORDS & LIBRARY	278,649		278,649	16
17	01700	SOCIAL SERVICE	67,264		67,264	17
19	01900	NONPHYSICIAN ANESTHETISTS	474,804	-474,804		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	1,833,678	-50,460	1,783,218	30
31	03100	INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS						
50	05000	OPERATING ROOM	917,655	-65,500	852,155	50
53	05300	ANESTHESIOLOGY				53
54	05400	RADIOLOGY-DIAGNOSTIC	912,125		912,125	54
57	05700	COMPUTED TOMOGRAPHY (CT) SCAN	243,426		243,426	57
58	05800	MAGNETIC RESONANCE IMAGING (MRI)	90,779		90,779	58
60	06000	LABORATORY	1,484,738		1,484,738	60
62.30	06250	BLOOD, CLOTTING FOR HEMOPHILIACS				62.30
65	06500	RESPIRATORY THERAPY	497,836	-57,431	440,405	65
66	06600	PHYSICAL THERAPY	727,155	-84	727,071	66
67	06700	OCCUPATIONAL THERAPY				67
68	06800	SPEECH PATHOLOGY				68
69	06900	ELECTROCARDIOLOGY	92,799	-43,687	49,112	69
71	07100	MEDICAL SUPPLIES CHRGD TO PATIENTS	595,149		595,149	71
72	07200	IMPL. DEV. CHARGED TO PATIENT	21,817		21,817	72
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)	525,125		525,125	88
90	09000	CLINIC	155,781		155,781	90
90.01	09001	SALEM MEDICAL CLINIC				90.01
91	09100	EMERGENCY	2,895,275	-1,186,512	1,708,763	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)	24,789,926	-4,832,904	19,957,022	118
NONREIMBURSABLE COST CENTERS						
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	106,410		106,410	190
192	19200	PHYSICIANS' PRIVATE OFFICES	162,881		162,881	192
192.01	19201	TEMPORARILY IDLE SPACE				192.01
200		TOTAL (SUM OF LINES 118-199)	25,059,217	-4,832,904	20,226,313	200

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	INCREASE LINE #	SALARY	OTHER	
1 TO RECLASS CAFETERIA COST	A	CAFETERIA	11	180,384	280,819	1
500 TOTAL RECLASSIFICATIONS				180,384	280,819	500
CODE LETTER - A						
1 TO RECLASSIFY SUPPLY COST	B	MEDICAL SUPPLIES CHRGED TO PA	71	14,943	580,206	1
500 TOTAL RECLASSIFICATIONS				14,943	580,206	500
CODE LETTER - B						
1 TO RECLASS RENTALS	C	CAP REL COSTS-MVBLE EQUIP	2		791,903	1
2						2
3						3
4						4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
500 TOTAL RECLASSIFICATIONS					791,903	500
CODE LETTER - C						
1 TO RECLASS CRNA COST	D	NONPHYSICIAN ANESTHETISTS	19		474,804	1
500 TOTAL RECLASSIFICATIONS					474,804	500
CODE LETTER - D						
1 TO RECLASS REMAINING ANESTHESIA SUPP	E	OPERATING ROOM	50		27,767	1
500 TOTAL RECLASSIFICATIONS					27,767	500
CODE LETTER - E						
1 TO RECLASS INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		390,430	1
500 TOTAL RECLASSIFICATIONS					390,430	500
CODE LETTER - F						
1 TO RECLASS PHYSICIAN PORTION FOR RHC	G	RURAL HEALTH CLINIC (RHC)	88		29,481	1
500 TOTAL RECLASSIFICATIONS					29,481	500
CODE LETTER - G						
1 TO RECLASS OTHER CAPITAL COSTS	H	CAP REL COSTS-BLDG & FIXT	1		77,553	1
500 TOTAL RECLASSIFICATIONS					77,553	500
CODE LETTER - H						
1 TO RECLASS PHYSICIAN ADMIN TIME	I	ADULTS & PEDIATRICS	30		1,667	1
500 TOTAL RECLASSIFICATIONS					1,667	500
CODE LETTER - I						
GRAND TOTAL (INCREASES)				195,327	2,654,630	

RECLASSIFICATIONS

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE	SALARY	OTHER	WKST A-7	
			LINE #			REF.	
	1	6	7	8	9	10	
1 TO RECLASS CAFETERIA COST	A	DIETARY	10	180,384	280,819		1
500 TOTAL RECLASSIFICATIONS				180,384	280,819		500
1 TO RECLASSIFY SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	14.02	14,943	580,206		1
500 TOTAL RECLASSIFICATIONS				14,943	580,206		500
1 TO RECLASS RENTALS	C	ADMINISTRATIVE & ACCOUNTING	5.01		11,366	10	1
2		OPERATION OF PLANT	7		4,833		2
3		DIETARY	10		946		3
4		MEDICAL RECORDS & LIBRARY	16		1,841		4
5		ADULTS & PEDIATRICS	30		22,098		5
6		OPERATING ROOM	50		145,525		6
7		RADIOLOGY-DIAGNOSTIC	54		48,623		7
8		LABORATORY	60		65,732		8
9		RESPIRATORY THERAPY	65		12,390		9
10		PHYSICAL THERAPY	66		942		10
11		CLINIC	90		3,163		11
12		RURAL HEALTH CLINIC (RHC)	88		188		12
13		MAGNETIC RESONANCE IMAGING (M	58		454,890		13
14		PHYSICIANS' PRIVATE OFFICES	192		831		14
15		EMERGENCY	91		18,535		15
500 TOTAL RECLASSIFICATIONS					791,903		500
1 TO RECLASS CRNA COST	D	ANESTHESIOLOGY	53		474,804		1
500 TOTAL RECLASSIFICATIONS					474,804		500
1 TO RECLASS REMAINING ANESTHESIA SUPP	E	ANESTHESIOLOGY	53		27,767		1
500 TOTAL RECLASSIFICATIONS					27,767		500
1 TO RECLASS INTEREST EXPENSE	F	ADMINISTRATIVE & ACCOUNTING	5.01		390,430	14	1
500 TOTAL RECLASSIFICATIONS					390,430		500
1 TO RECLASS PHYSICIAN PORTION FOR RHC	G	EMERGENCY	91		29,481		1
500 TOTAL RECLASSIFICATIONS					29,481		500
1 TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	5.01		77,553	14	1
500 TOTAL RECLASSIFICATIONS					77,553		500
1 TO RECLASS PHYSICIAN ADMIN TIME	I	PHYSICIANS' PRIVATE OFFICES	192		1,667		1
500 TOTAL RECLASSIFICATIONS					1,667		500
GRAND TOTAL (DECREASES)				195,327	2,654,630		

RECONCILIATION OF CAPITAL COST CENTERS

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	38,220		38,220		99,381	1
2 LAND IMPROVEMENTS	913,078	108,013		108,013		1,021,091	2
3 BUILDINGS AND FIXTURES	23,943,954	849,291		849,291	1,036	24,792,209	3
4 BUILDING IMPROVEMENTS						1,927,798	4
5 FIXED EQUIPMENT	1,898,294	29,504		29,504		1,927,798	5
6 MOVABLE EQUIPMENT	9,047,221	59,711		59,711	437,980	8,668,952	6
7 HIT DESIGNATED ASSETS	592,447	486,822		486,822		1,079,269	7
8 SUBTOTAL (SUM OF LINES 1-7)	36,456,155	1,571,561		1,571,561	439,016	37,588,700	8
9 RECONCILING ITEMS							9
10 TOTAL (LINE 7 MINUS LINE 9)	36,456,155	1,571,561		1,571,561	439,016	37,588,700	10

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

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
2 CAP REL COSTS-MVBLE EQUIP	856,140						856,140
3 TOTAL (SUM OF LINES 1-2)	2,046,346						2,046,346

PART III - RECONCILIATION OF CAPITAL COST CENTERS

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

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(2) (SUM OF COLS. 9-14) 15
							1 CAP REL COSTS-BLDG & FIXT
2 CAP REL COSTS-MVBLE EQUIP	856,140	791,903				-278,715	1,369,328
3 TOTAL	2,046,346	791,903				189,268	3,027,517

ADJUSTMENTS TO EXPENSES

LINE NO.	DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WORKSHEET A-8	
				COST CENTER	LINE NO.	WKST A-7	REF
		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	-2,566	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	-1,561	ADMINISTRATIVE & ACCOUNTING	5.01		7
8	TELEVISION AND RADIO SERVICE (CHAPTER 21)	A	-1,852	ADMINISTRATIVE & ACCOUNTING	5.01		8
9	PARKING LOT (CHAPTER 21)						9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,403,590				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	-102,439	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	-598	PHARMACY	15		17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS						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		RESPIRATORY THERAPY	65		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)			UTILIZATION REVIEW-SNF	114		25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1		26
27	DEPRECIATION--MOVABLE EQUIPMENT	B	-235,469	CAP REL COSTS-MVBLE EQUIP	2	14	27
28	NON-PHYSICIAN ANESTHETIST		-474,804	NONPHYSICIAN ANESTHETISTS	19		28
29	PHYSICIANS' ASSISTANT						29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67		30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (CHAPTER 14)	WKST A-8-3		SPEECH PATHOLOGY	68		31
32	CAH HIT ADJ FOR DEPRECIATION AND						32
33	PROVISION FOR BAD DEBTS	A	-2,315,065	ADMINISTRATIVE & ACCOUNTING	5.01		33
34	DIETARY REVENUE	B	-29,324	DIETARY	10		34
35	BUS OFFICE COSTS ASSOC W/ PHYS CHG	A	-26,730	BUSINESS SERVICES	5.02		35
36	TELEPHONE	A	-406	CAP REL COSTS-MVBLE EQUIP	2	14	36
37	PHYSICIAN RECRUITMENT	A	-119,898	ADMINISTRATIVE & ACCOUNTING	5.01		37
38	OTHER REVENUE	B	-160	ADMINISTRATIVE & ACCOUNTING	5.01		38
39	LOBBYING PORTION OF DUES	A	-13,209	ADMINISTRATIVE & ACCOUNTING	5.01		39
40	MARKETING	A	-61,103	EMPLOYEE BENEFITS	4		40
41	OTHER REVENUE	B	-428	ADMINISTRATIVE & ACCOUNTING	5.01		41
42	SPOUSE MEAL COST	A	-660	ADMINISTRATIVE & ACCOUNTING	5.01		42
43	ATHLETIC TRAINER	A	-84	PHYSICAL THERAPY	66		43
44	ADVERTISING	A	-118	ADMINISTRATIVE & ACCOUNTING	5.01		44
45							45
46							46
47	IMPAIRED ASSETS	A	-42,840	CAP REL COSTS-MVBLE EQUIP	2	14	47
48							48
49							49
50	TOTAL (SUM OF LINES 1 THRU 49) TRANSFER TO WKST A, COL. 6, LINE 200)		-4,832,904				50

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

WORKSHEET A-8-1

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

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL. 5)	NET ADJ- USTMENTS (COL. 4-5)	WKST A-7 REF
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4) 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	PERCENT OF OWNERSHIP	----- RELATED ORGANIZATION(S) AND/OR HOME OFFICE -----		
			NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS
1	2	3	4	5	6
6					
7					
8					
9					
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:

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	5 PERCENT OF UNAD- JUSTED RCE LIMIT
1	2	3	4	5	6	7	8	9
1	50 OPERATING ROOM	65,500	65,500					
2	60 LABORATORY	51,401		51,401				
3	65 RESPIRATORY THERAPY	57,021	57,021					
4	65 RESPIRATORY THERAPY	410	410					
5	69 ELECTROCARDIOLOGY	43,687	43,687					
6	91 EMERGENCY	1,885,412	1,886,512	698,900				
7	53 ANESTHESIOLOGY	20,000		20,000				
8	30 ADULTS & PEDIATRICS	50,460	50,460					
200	TOTAL	2,173,891	1,403,590	770,301				

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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.		11	12	13	14	15	16	17	18	
1	50	OPERATING ROOM			OR				65,500	1
2	60	LABORATORY			LABORATORY					2
3	65	RESPIRATORY THERAPY			RESPIRATORY THE				57,021	3
4	65	RESPIRATORY THERAPY			RESPIRATORY THE				410	4
5	69	ELECTROCARDIOLOGY			ELECTROCARDIOLO				43,687	5
6	91	EMERGENCY			EMERGENCY				1,186,512	6
7	53	ANESTHESIOLOGY			ANESTHESIOLOGY					7
8	30	ADULTS & PEDIATRICS			HOSPITALIST				50,460	8
200		TOTAL							1,403,590	200

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
 FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3
 PARTS I & II

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

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES)					24	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					360	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		1,740.00				9
10	AHSEA		69.83				10
11	STANDARD TRAVEL ALLOWANCE	34.92	34.92				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					121,504	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					121,504	17
18	AIDES						18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					121,504	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					121,504	23

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
FURNISHED BY OUTSIDE SUPPLIERS ON OR AFTER APRIL 10, 1998

WORKSHEET A-8-3
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
24 THERAPISTS	25
25 ASSISTANTS	26
26 SUBTOTAL	27
27 STANDARD TRAVEL EXPENSE	28
28 TOTAL STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE AT THE PROVIDER SITE	
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	29
29 THERAPISTS	30
30 ASSISTANTS	31
31 SUBTOTAL	32
32 OPTIONAL TRAVEL EXPENSE	33
33 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	34
34 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	35
35 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	

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

STANDARD TRAVEL EXPENSE	36
36 THERAPISTS	37
37 ASSISTANTS	38
38 SUBTOTAL	39
39 STANDARD TRAVEL EXPENSE	
OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	40
40 THERAPISTS	41
41 ASSISTANTS	42
42 SUBTOTAL	43
43 OPTIONAL TRAVEL EXPENSE	
TOTAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE - OFFSITE SERVICES	44
44 STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	45
45 OPTIONAL TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE	46
46 OPTIONAL TRAVEL ALLOWANCE AND OPTIONAL TRAVEL EXPENSE	

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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						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					121,504	57
58						58
59						59
60						60
61						61
62						62
63					121,504	63
64					83,287	64
65						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					.500	7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		3,442.00		3,803.00		9
10	AHSEA		73.69		55.27		10
11	STANDARD TRAVEL ALLOWANCE	36.85	36.85				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					253,641	15
16	ASSISTANTS						16
17	SUBTOTAL ALLOWANCE AMOUNT					253,641	17
18	AIDES					210,192	18
19	TRAINEES						19
20	TOTAL ALLOWANCE AMOUNT					463,833	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES						22
23	TOTAL SALARY EQUIVALENCY					463,833	23

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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

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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 [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					463,833	57
58						58
59						59
60						60
61						61
62						62
63					463,833	63
64					292,477	64
65						65

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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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)				11	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK				165	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				5.00	6
7	STANDARD TRAVEL EXPENSE RATE					7
8	OPTIONAL TRAVEL EXPENSE RATE PER MILE					8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES
		1	2	3	4	5
9	TOTAL HOURS WORKED		28.00			
10	AHSEA		67.12			
11	STANDARD TRAVEL ALLOWANCE	33.56	33.56			
12	NO OF TRAVEL HRS (PROV SITE)					12.01
12.01	NO OF TRAVEL HRS (OFFSITE)					13
13	MILES DRIVEN (PROV SITE)					13.01
13.01	MILES DRIVEN (OFFSITE)					

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS				1,879	14
15	THERAPISTS					15
16	ASSISTANTS				1,879	16
17	SUBTOTAL ALLOWANCE AMOUNT					17
18	AIDES					18
19	TRAINEES				1,879	19
20	TOTAL ALLOWANCE AMOUNT				67.11	20
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES				11,073	21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES				11,073	22
23	TOTAL SALARY EQUIVALENCY					23

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES
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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

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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						47
48						48
49						49
50						50
51						51
52						52
53						53
54						54
55						55
56						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57					11,073	57
58						58
59						59
60						60
61						61
62						62
63					11,073	63
64					1,271	64
65						65

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
 PART I

COST CENTER DESCRIPTION	ALLOCATION (FROM WKST A, COL.7) 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	EMPLOYEE BENEFITS 4	SUBTOTAL (COLS.0-4) 4A	
GENERAL SERVICE COST CENTERS						
1 CAP REL COSTS-BLDG & FIXT	1,658,189	1,658,189				1
2 CAP REL COSTS-MVBLE EQUIP	1,369,328		1,369,328			2
4 EMPLOYEE BENEFITS	1,805,004	8,994	1,401	1,815,399		4
5.01 ADMINISTRATIVE & ACCOUNTING	1,136,368	434,441	16,761	140,051	1,727,621	5.01
5.02 BUSINESS SERVICES	1,164,748	96,890	276,576	144,151	1,682,365	5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	751,803	255,970	23,519	49,867	1,081,159	7
8 LAUNDRY & LINEN SERVICE	49,025	14,033	1,016	7,039	71,113	8
9 HOUSEKEEPING	207,174	12,231		31,179	250,584	9
10 DIETARY	145,111	45,271	3,260	16,262	209,904	10
11 CAFETERIA	358,764			42,766	401,530	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	90,493	25,386	633	16,564	133,076	13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING	102,370	21,368	388	20,330	144,456	14.01
14.02 CENTRAL SERVICES & SUPPLY	101				101	14.02
15 PHARMACY	1,182,967	11,848		10,452	1,205,267	15
16 MEDICAL RECORDS & LIBRARY	278,649	28,640	26,074	34,064	367,427	16
17 SOCIAL SERVICE	67,264			13,820	81,084	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	1,783,218	87,497	62,211	373,257	2,306,183	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	852,155	96,778	197,634	149,183	1,295,750	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	912,125	46,180	204,232	130,702	1,293,239	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	243,426	7,654	3,180	18,409	272,669	57
58 MAGNETIC RESONANCE IMAGING (MRI)	90,779		377,958	18,848	487,585	58
60 LABORATORY	1,484,738	97,798	85,646	135,826	1,804,008	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	440,405	51,682	20,125	71,341	583,553	65
66 PHYSICAL THERAPY	727,071	89,666	5,714		822,451	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	49,112		8,762	9,434	67,308	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	595,149	15,308	344	3,543	614,344	71
72 IMPL. DEV. CHARGED TO PATIENT	21,817				21,817	72
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)	525,125	20,666	434	103,926	650,151	88
90 CLINIC	155,781	12,550	5,430	31,469	205,230	90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	1,708,763	70,498	38,677	208,071	2,026,009	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)	19,957,022	1,551,349	1,359,975	1,780,554	19,805,984	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	106,410	16,584	4,350	11,369	138,713	190
192 PHYSICIANS' PRIVATE OFFICES	162,881	31,558	5,003	23,476	222,918	192
192.01 TEMPORARILY IDLE SPACE		58,698			58,698	192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	20,226,313	1,658,189	1,369,328	1,815,399	20,226,313	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
1 CAP REL COSTS-BLDG & FIXT						2
2 CAP REL COSTS-MVBLE EQUIP						4
4 EMPLOYEE BENEFITS						5.01
5.01 ADMINISTRATIVE & ACCOUNTING	1,727,621					5.02
5.02 BUSINESS SERVICES	157,119	1,839,484				6
6 MAINTENANCE & REPAIRS						7
7 OPERATION OF PLANT	100,972		1,182,131			8
8 LAUNDRY & LINEN SERVICE	6,641		19,247	97,001		9
9 HOUSEKEEPING	23,403		16,775	4,778	295,540	10
10 DIETARY	19,603		62,092	541	4,776	11
11 CAFETERIA	37,500					12
12 MAINTENANCE OF PERSONNEL						13
13 NURSING ADMINISTRATION	12,428		34,819			14
14 CENTRAL SERVICES & SUPPLY						14.01
14.01 PURCHASING	13,491		29,307			14.02
14.02 CENTRAL SERVICES & SUPPLY	9				5,672	15
15 PHARMACY	112,562		16,250		6,568	16
16 MEDICAL RECORDS & LIBRARY	34,315		39,280		4,179	17
17 SOCIAL SERVICE	7,573					19
19 NONPHYSICIAN ANESTHETISTS						20
20 NURSING SCHOOL						21
21 I&R SRVCS-SALARY & FRINGES APPRVD						22
22 I&R SRVCS-OTHER PRGM COSTS APPRVD						23
23 PARAMED ED PRGM-(SPECIFY)						
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	215,369	116,449	120,007	54,187	116,726	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	121,013	113,921	132,735	10,894	28,658	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	120,778	201,880	63,339	11,982	28,658	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	25,465	307,039	10,498		2,687	57
58 MAGNETIC RESONANCE IMAGING (MRI)	45,537	64,242			299	58
60 LABORATORY	168,480	416,169	134,135		22,389	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	54,499	101,262	70,884		10,448	65
66 PHYSICAL THERAPY	76,810	91,694	122,981	4,146	11,045	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY					1,194	68
69 ELECTROCARDIOLOGY	6,286	32,002				69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	57,375	69,240	20,996	313		71
72 IMPL. DEV. CHARGED TO PATIENT	2,038					72
73 DRUGS CHARGED TO PATIENTS		98,335				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)	60,719	37,424	28,345		11,642	88
90 CLINIC	19,167	25,826	17,213			90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	189,213	148,515	96,692	10,160	26,270	91
92 OBSERVATION BEDS						92
OTHER REIMBURSABLE COST CENTERS						
99.10 CORE						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)	1,688,365	1,823,998	1,035,595	97,001	281,211	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,955		22,746			190
192 PHYSICIANS' PRIVATE OFFICES	20,819	15,486	43,283		14,329	192
192.01 TEMPORARILY IDLE SPACE	5,482		80,507			192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	1,727,621	1,839,484	1,182,131	97,001	295,540	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	296,916					10
11 CAFETERIA		439,030				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		4,606	184,929			13
14 CENTRAL SERVICES & SUPPLY		7,122		194,376		14
14.01 PURCHASING				496	6,278	14.01
14.02 CENTRAL SERVICES & SUPPLY				1,290		14.02
15 PHARMACY		4,819		537		15
16 MEDICAL RECORDS & LIBRARY		17,716				16
17 SOCIAL SERVICE		3,543				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	296,916	121,635	90,375	11,394		30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		39,400	28,553	22,666		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		40,852		16,216		54
57 COMPUTED TOMOGRAPHY (CT) SCAN		4,996		4,852		57
58 MAGNETIC RESONANCE IMAGING (MRI)		5,527		926		58
60 LABORATORY		50,242		110,402		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		25,829		4,651		65
66 PHYSICAL THERAPY				2,204	11	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY				1,107		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		2,232			6,267	71
72 IMPL. DEV. CHARGED TO PATIENT						72
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)		29,621	22,052	2,990		88
90 CLINIC		9,460		2,096		90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY		59,135	43,949	9,258		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)	296,916	426,735	184,929	191,085	6,278	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,980		992		190
192 PHYSICIANS' PRIVATE OFFICES		5,315		2,299		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)	296,916	439,030	184,929	194,376	6,278	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
1 CAP REL COSTS-BLDG & FIXT					2
2 CAP REL COSTS-MVBLE EQUIP					4
4 EMPLOYEE BENEFITS					5.01
5.01 ADMINISTRATIVE & ACCOUNTING					5.02
5.02 BUSINESS SERVICES					6
6 MAINTENANCE & REPAIRS					7
7 OPERATION OF PLANT					8
8 LAUNDRY & LINEN SERVICE					9
9 HOUSEKEEPING					10
10 DIETARY					11
11 CAFETERIA					12
12 MAINTENANCE OF PERSONNEL					13
13 NURSING ADMINISTRATION					14
14 CENTRAL SERVICES & SUPPLY					14.01
14.01 PURCHASING					14.02
14.02 CENTRAL SERVICES & SUPPLY					15
15 PHARMACY	1,346,756				16
16 MEDICAL RECORDS & LIBRARY		463,454			17
17 SOCIAL SERVICE			92,200		19
19 NONPHYSICIAN ANESTHETISTS					20
20 NURSING SCHOOL					21
21 I&R SRVCES-SALARY & FRINGES APPRVD					22
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					23
23 PARAMED ED PRGM-(SPECIFY)					
INPATIENT ROUTINE SERV COST CENTERS					30
30 ADULTS & PEDIATRICS		146,242	92,200	3,687,683	31
31 INTENSIVE CARE UNIT					
ANCILLARY SERVICE COST CENTERS					50
50 OPERATING ROOM		33,889		1,827,479	53
53 ANESTHESIOLOGY					54
54 RADIOLOGY-DIAGNOSTIC		1,527		1,778,471	57
57 COMPUTED TOMOGRAPHY (CT) SCAN				628,206	58
58 MAGNETIC RESONANCE IMAGING (MRI)				604,116	60
60 LABORATORY		126,091		2,831,916	62.30
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					65
65 RESPIRATORY THERAPY		23,203		874,329	66
66 PHYSICAL THERAPY		30,225		1,161,567	67
67 OCCUPATIONAL THERAPY					68
68 SPEECH PATHOLOGY					69
69 ELECTROCARDIOLOGY		11,907		119,804	71
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				770,767	72
72 IMPL. DEV. CHARGED TO PATIENT				23,855	73
73 DRUGS CHARGED TO PATIENTS	1,346,756			1,445,091	76.97
76.97 CARDIAC REHABILITATION					76.98
76.98 HYPERBARIC OXYGEN THERAPY					76.99
76.99 LITHOTRIPSY					
OUTPATIENT SERVICE COST CENTERS					88
88 RURAL HEALTH CLINIC (RHC)		13,433		856,377	90
90 CLINIC				278,992	90.01
90.01 SALEM MEDICAL CLINIC					91
91 EMERGENCY		76,937		2,686,138	92
92 OBSERVATION BEDS					
OTHER REIMBURSABLE COST CENTERS					99.10
99.10 CORF					99.20
99.20 OUTPATIENT PHYSICAL THERAPY					99.30
99.30 OUTPATIENT OCCUPATIONAL THERAPY					99.40
99.40 OUTPATIENT SPEECH PATHOLOGY					
SPECIAL PURPOSE COST CENTERS					118
118 SUBTOTALS (SUM OF LINES 1-117)	1,346,756	463,454	92,200	19,574,791	
NONREIMBURSABLE COST CENTERS					190
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				182,386	192
192 PHYSICIANS' PRIVATE OFFICES				324,449	192.01
192.01 TEMPORARILY IDLE SPACE				144,687	200
200 CROSS FOOT ADJUSTMENTS					201
201 NEGATIVE COST CENTER					202
202 TOTAL (SUM OF LINES 118-201)	1,346,756	463,454	92,200	20,226,313	

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	3,687,683	30
31	INTENSIVE CARE UNIT		31
ANCILLARY SERVICE COST CENTERS			
50	OPERATING ROOM	1,827,479	50
53	ANESTHESIOLOGY		53
54	RADIOLOGY-DIAGNOSTIC	1,778,471	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	628,206	57
58	MAGNETIC RESONANCE IMAGING (MRI)	604,116	58
60	LABORATORY	2,831,916	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		62.30
65	RESPIRATORY THERAPY	874,329	65
66	PHYSICAL THERAPY	1,161,567	66
67	OCCUPATIONAL THERAPY		67
68	SPEECH PATHOLOGY		68
69	ELECTROCARDIOLOGY	119,804	69
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	770,767	71
72	IMPL. DEV. CHARGED TO PATIENT	23,855	72
73	DRUGS CHARGED TO PATIENTS	1,445,091	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)	856,377	88
90	CLINIC	278,992	90
90.01	SALEM MEDICAL CLINIC		90.01
91	EMERGENCY	2,686,138	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)	19,574,791	118
NONREIMBURSABLE COST CENTERS			
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	182,386	190
192	PHYSICIANS' PRIVATE OFFICES	324,449	192
192.01	TEMPORARILY IDLE SPACE	144,687	192.01
200	CROSS FOOT ADJUSTMENTS		200
201	NEGATIVE COST CENTER		201
202	TOTAL (SUM OF LINES 118-201)	20,226,313	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS 4	
GENERAL SERVICE COST CENTERS						1
1 CAP REL COSTS-BLDG & FIXT						2
2 CAP REL COSTS-MVBLE EQUIP						4
4 EMPLOYEE BENEFITS					10,395	5.01
5.01 ADMINISTRATIVE & ACCOUNTING		8,994	1,401	10,395	802	5.02
5.02 BUSINESS SERVICES		434,441	16,761	451,202	826	6
6 MAINTENANCE & REPAIRS		96,890	276,576	373,466		7
7 OPERATION OF PLANT					286	8
8 LAUNDRY & LINEN SERVICE		255,970	23,519	279,489	40	9
9 HOUSEKEEPING		14,033	1,016	15,049	179	10
10 DIETARY		12,231		12,231	93	11
11 CAFETERIA		45,271	3,260	48,531	245	12
12 MAINTENANCE OF PERSONNEL						13
13 NURSING ADMINISTRATION		25,386	633	26,019	95	14
14 CENTRAL SERVICES & SUPPLY						14.01
14.01 PURCHASING		21,368	388	21,756	116	14.02
14.02 CENTRAL SERVICES & SUPPLY						15
15 PHARMACY		11,848		11,848	60	16
16 MEDICAL RECORDS & LIBRARY		28,640	26,074	54,714	195	17
17 SOCIAL SERVICE					79	19
19 NONPHYSICIAN ANESTHETISTS						20
20 NURSING SCHOOL						21
21 I&R SRVCES-SALARY & FRINGES APPRVD						22
22 I&R SRVCES-OTHER PRGM COSTS APPRVD						23
23 PARAMED ED PRGM-(SPECIFY)						30
INPATIENT ROUTINE SERV COST CENTERS						31
30 ADULTS & PEDIATRICS		87,497	62,211	149,708	2,135	50
31 INTENSIVE CARE UNIT						53
ANCILLARY SERVICE COST CENTERS						54
50 OPERATING ROOM		96,778	197,634	294,412	855	57
53 ANESTHESIOLOGY						58
54 RADIOLOGY-DIAGNOSTIC		46,180	204,232	250,412	749	59
57 COMPUTED TOMOGRAPHY (CT) SCAN		7,654	3,180	10,834	105	60
58 MAGNETIC RESONANCE IMAGING (MRI)			377,958	377,958	108	62.30
60 LABORATORY		97,798	85,646	183,444	778	65
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						66
65 RESPIRATORY THERAPY		51,682	20,125	71,807	409	67
66 PHYSICAL THERAPY		89,666	5,714	95,380		68
67 OCCUPATIONAL THERAPY						69
68 SPEECH PATHOLOGY						71
69 ELECTROCARDIOLOGY			8,762	8,762	54	72
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		15,308	344	15,652	20	73
72 IMPL. DEV. CHARGED TO PATIENT						76.97
73 DRUGS CHARGED TO PATIENTS						76.98
76.97 CARDIAC REHABILITATION						76.99
76.98 HYPERBARIC OXYGEN THERAPY						88
76.99 LITHOTRIPSY						90
OUTPATIENT SERVICE COST CENTERS						90.01
88 RURAL HEALTH CLINIC (RHC)		20,666	434	21,100	595	91
90 CLINIC		12,550	5,430	17,980	180	92
90.01 SALEM MEDICAL CLINIC						99.10
91 EMERGENCY		70,498	38,677	109,175	1,192	99.20
92 OBSERVATION BEDS						99.30
OTHER REIMBURSABLE COST CENTERS						99.40
99.10 CORF						118
99.20 OUTPATIENT PHYSICAL THERAPY						190
99.30 OUTPATIENT OCCUPATIONAL THERAPY						192
99.40 OUTPATIENT SPEECH PATHOLOGY						192.01
SPECIAL PURPOSE COST CENTERS						200
118 SUBTOTALS (SUM OF LINES 1-117)		1,551,349	1,359,975	2,911,324	10,196	201
NONREIMBURSABLE COST CENTERS						202
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		16,584	4,350	20,934	65	201
192 PHYSICIANS' PRIVATE OFFICES		31,558	5,003	36,561	134	202
192.01 TEMPORARILY IDLE SPACE		58,698		58,698		201
200 CROSS FOOT ADJUSTMENTS						202
201 NEGATIVE COST CENTER						202
202 TOTAL (SUM OF LINES 118-201)		1,658,189	1,369,328	3,027,517	10,395	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

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	452,004					5.01
5.02 BUSINESS SERVICES	41,107	415,399				5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	26,417		306,192			7
8 LAUNDRY & LINEN SERVICE	1,738		4,985	21,812		8
9 HOUSEKEEPING	6,123		4,345	1,074	23,952	9
10 DIETARY	5,129		16,083	122	387	10
11 CAFETERIA	9,811					11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	3,252		9,019			13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING	3,530		7,591			14.01
14.02 CENTRAL SERVICES & SUPPLY	2				460	14.02
15 PHARMACY	29,449		4,209		532	15
16 MEDICAL RECORDS & LIBRARY	8,978		10,174		339	16
17 SOCIAL SERVICE	1,981					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	56,354	26,297	31,084	12,185	9,458	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	31,660	25,726	34,381	2,450	2,323	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	31,599	45,589	16,406	2,694	2,323	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	6,662	69,336	2,719		218	57
58 MAGNETIC RESONANCE IMAGING (MRI)	11,914	14,507			24	58
60 LABORATORY	44,079	93,983	34,743		1,815	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	14,259	22,867	18,360		847	65
66 PHYSICAL THERAPY	20,096	20,707	31,854	932	895	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	1,645	7,227			97	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	15,011	15,636	5,438	70		71
72 IMPL. DEV. CHARGED TO PATIENT	533					72
73 DRUGS CHARGED TO PATIENTS		22,206				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)	15,886	8,451	7,342		944	88
90 CLINIC	5,015	5,832	4,458			90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	49,504	33,538	25,045	2,285	2,129	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)	441,734	411,902	268,236	21,812	22,791	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,389		5,892			190
192 PHYSICIANS' PRIVATE OFFICES	5,447	3,497	11,211		1,161	192
192.01 TEMPORARILY IDLE SPACE	1,434		20,853			192.01
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 TOTAL (SUM OF LINES 118-201)	452,004	415,399	306,192	21,812	23,952	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	70,345					10
11 CAFETERIA		10,056				11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION		106	38,491			13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING		163		33,156		14.01
14.02 CENTRAL SERVICES & SUPPLY				85	547	14.02
15 PHARMACY		110		220		15
16 MEDICAL RECORDS & LIBRARY		406		92		16
17 SOCIAL SERVICE		81				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	70,345	2,786	18,811	1,944		30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM		902	5,943	3,866		50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC		936		2,766		54
57 COMPUTED TOMOGRAPHY (CT) SCAN		114		828		57
58 MAGNETIC RESONANCE IMAGING (MRI)		127		158		58
60 LABORATORY		1,151		18,831		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY		592		793		65
66 PHYSICAL THERAPY				376	1	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY				189		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS		51			546	71
72 IMPL. DEV. CHARGED TO PATIENT						72
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)		678	4,590	510		88
90 CLINIC		217		358		90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY		1,354	9,147	1,579		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)	70,345	9,774	38,491	32,595	547	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN		160		169		190
192 PHYSICIANS' PRIVATE OFFICES		122		392		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)	70,345	10,056	38,491	33,156	547	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
1 CAP REL COSTS-BLDG & FIXT					2
2 CAP REL COSTS-MVBLE EQUIP					4
4 EMPLOYEE BENEFITS					5.01
5.01 ADMINISTRATIVE & ACCOUNTING					5.02
5.02 BUSINESS SERVICES					6
6 MAINTENANCE & REPAIRS					7
7 OPERATION OF PLANT					8
8 LAUNDRY & LINEN SERVICE					9
9 HOUSEKEEPING					10
10 DIETARY					11
11 CAFETERIA					12
12 MAINTENANCE OF PERSONNEL					13
13 NURSING ADMINISTRATION					14
14 CENTRAL SERVICES & SUPPLY					14.01
14.01 PURCHASING					14.02
14.02 CENTRAL SERVICES & SUPPLY					15
15 PHARMACY	46,428				16
16 MEDICAL RECORDS & LIBRARY		74,898			17
17 SOCIAL SERVICE			2,141		19
19 NONPHYSICIAN ANESTHETISTS					20
20 NURSING SCHOOL					21
21 I&R SRVCES-SALARY & FRINGES APPRVD					22
22 I&R SRVCES-OTHER PRGM COSTS APPRVD					23
23 PARAMED ED PRGM-(SPECIFY)					
INPATIENT ROUTINE SERV COST CENTERS					
30 ADULTS & PEDIATRICS		23,633	2,141	406,881	30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM		5,477		407,995	50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC		247		353,721	54
57 COMPUTED TOMOGRAPHY (CT) SCAN				90,816	57
58 MAGNETIC RESONANCE IMAGING (MRI)				404,796	58
60 LABORATORY		20,377		399,201	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY		3,750		133,684	65
66 PHYSICAL THERAPY		4,885		175,126	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY		1,924		19,898	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS				52,424	71
72 IMPL. DEV. CHARGED TO PATIENT				533	72
73 DRUGS CHARGED TO PATIENTS	46,428			68,634	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)		2,171		62,267	88
90 CLINIC				34,040	90
90.01 SALEM MEDICAL CLINIC					90.01
91 EMERGENCY		12,434		247,382	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)	46,428	74,898	2,141	2,857,398	118
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN				30,609	190
192 PHYSICIANS' PRIVATE OFFICES				58,525	192
192.01 TEMPORARILY IDLE SPACE				80,985	192.01
200 CROSS FOOT ADJUSTMENTS					200
201 NEGATIVE COST CENTER					201
202 TOTAL (SUM OF LINES 118-201)	46,428	74,898	2,141	3,027,517	202

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
 PART II

COST CENTER DESCRIPTION		TOTAL	
		26	
	GENERAL SERVICE COST CENTERS		1
1	CAP REL COSTS-BLDG & FIXT		2
2	CAP REL COSTS-MVBLE EQUIP		4
4	EMPLOYEE BENEFITS		5.01
5.01	ADMINISTRATIVE & ACCOUNTING		5.02
5.02	BUSINESS SERVICES		6
6	MAINTENANCE & REPAIRS		7
7	OPERATION OF PLANT		8
8	LAUNDRY & LINEN SERVICE		9
9	HOUSEKEEPING		10
10	DIETARY		11
11	CAFETERIA		12
12	MAINTENANCE OF PERSONNEL		13
13	NURSING ADMINISTRATION		14
14	CENTRAL SERVICES & SUPPLY		14.01
14.01	PURCHASING		14.02
14.02	CENTRAL SERVICES & SUPPLY		15
15	PHARMACY		16
16	MEDICAL RECORDS & LIBRARY		17
17	SOCIAL SERVICE		19
19	NONPHYSICIAN ANESTHETISTS		20
20	NURSING SCHOOL		21
21	I&R SRVCES-SALARY & FRINGES APPRVD		22
22	I&R SRVCES-OTHER PRGM COSTS APPRVD		23
23	PARAMED ED PRGM-(SPECIFY)		
	INPATIENT ROUTINE SERV COST CENTERS		30
30	ADULTS & PEDIATRICS	406,881	31
31	INTENSIVE CARE UNIT		
	ANCILLARY SERVICE COST CENTERS		50
50	OPERATING ROOM	407,995	53
53	ANESTHESIOLOGY		54
54	RADIOLOGY-DIAGNOSTIC	353,721	57
57	COMPUTED TOMOGRAPHY (CT) SCAN	90,816	58
58	MAGNETIC RESONANCE IMAGING (MRI)	404,796	60
60	LABORATORY	399,201	62.30
62.30	BLOOD CLOTTING FOR HEMOPHILIACS		65
65	RESPIRATORY THERAPY	133,684	66
66	PHYSICAL THERAPY	175,126	67
67	OCCUPATIONAL THERAPY		68
68	SPEECH PATHOLOGY		69
69	ELECTROCARDIOLOGY	19,898	71
71	MEDICAL SUPPLIES CHRGD TO PATIENTS	52,424	72
72	IMPL. DEV. CHARGED TO PATIENT	533	73
73	DRUGS CHARGED TO PATIENTS	68,634	76.97
76.97	CARDIAC REHABILITATION		76.98
76.98	HYPERBARIC OXYGEN THERAPY		76.99
76.99	LITHOTRIPSY		
	OUTPATIENT SERVICE COST CENTERS		88
88	RURAL HEALTH CLINIC (RHC)	62,267	90
90	CLINIC	34,040	90.01
90.01	SALEM MEDICAL CLINIC		91
91	EMERGENCY	247,382	92
92	OBSERVATION BEDS		
	OTHER REIMBURSABLE COST CENTERS		99.10
99.10	CORF		99.20
99.20	OUTPATIENT PHYSICAL THERAPY		99.30
99.30	OUTPATIENT OCCUPATIONAL THERAPY		99.40
99.40	OUTPATIENT SPEECH PATHOLOGY		
	SPECIAL PURPOSE COST CENTERS		118
118	SUBTOTALS (SUM OF LINES 1-117)	2,857,398	
	NONREIMBURSABLE COST CENTERS		190
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	30,609	192
192	PHYSICIANS' PRIVATE OFFICES	58,525	192.01
192.01	TEMPORARILY IDLE SPACE	80,985	200
200	CROSS FOOT ADJUSTMENTS		201
201	NEGATIVE COST CENTER		202
202	TOTAL (SUM OF LINES 118-201)	3,027,517	

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	103,986					1
2 CAP REL COSTS-MVBLE EQUIP		1,648,042				2
4 EMPLOYEE BENEFITS	564	1,686	7,657,254			4
5.01 ADMINISTRATIVE & ACCOUNTING	27,244	20,172	590,727	-1,727,621	18,498,692	5.01
5.02 BUSINESS SERVICES	6,076	332,870	608,021		1,682,365	5.02
6 MAINTENANCE & REPAIRS						6
7 OPERATION OF PLANT	16,052	28,306	210,336		1,081,159	7
8 LAUNDRY & LINEN SERVICE	880	1,223	29,691		71,113	8
9 HOUSEKEEPING	767		131,511		250,584	9
10 DIETARY	2,839	3,924	68,594		209,904	10
11 CAFETERIA			180,384		401,530	11
12 MAINTENANCE OF PERSONNEL						12
13 NURSING ADMINISTRATION	1,592	762	69,867		133,076	13
14 CENTRAL SERVICES & SUPPLY						14
14.01 PURCHASING	1,340	467	85,752		144,456	14.01
14.02 CENTRAL SERVICES & SUPPLY					101	14.02
15 PHARMACY	743		44,087		1,205,267	15
16 MEDICAL RECORDS & LIBRARY	1,796	31,381	143,682		367,427	16
17 SOCIAL SERVICE			58,292		81,084	17
19 NONPHYSICIAN ANESTHETISTS						19
20 NURSING SCHOOL						20
21 I&R SRVCS-SALARY & FRINGES APPRVD						21
22 I&R SRVCS-OTHER PRGM COSTS APPRVD						22
23 PARAMED ED PRGM-(SPECIFY)						23
INPATIENT ROUTINE SERV COST CENTERS						
30 ADULTS & PEDIATRICS	5,487	74,873	1,574,374		2,306,183	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	6,069	237,860	629,245		1,295,750	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	2,896	245,802	551,296		1,293,239	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	480	3,827	77,648		272,669	57
58 MAGNETIC RESONANCE IMAGING (MRI)		454,890	79,500		487,585	58
60 LABORATORY	6,133	103,079	572,907		1,804,008	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	3,241	24,221	300,912		583,553	65
66 PHYSICAL THERAPY	5,623	6,877			822,451	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY		10,546	39,791		67,308	69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	960	414	14,943		614,344	71
72 IMPL. DEV. CHARGED TO PATIENT					21,817	72
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	522	438,355		650,151	88
90 CLINIC	787	6,535	132,734		205,230	90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	4,421	46,549	877,632		2,026,009	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)	97,286	1,636,786	7,510,281	-1,727,621	18,078,363	118
NONREIMBURSABLE COST CENTERS						
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,040	5,235	47,954		138,713	190
192 PHYSICIANS' PRIVATE OFFICES	1,979	6,021	99,019		222,918	192
192.01 TEMPORARILY IDLE SPACE	3,681				58,698	192.01

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

VERSION: 2012.11
 08/21/2013 13:59

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAP BLDGS & FIXTURES SQUARE FEET 1	CAP MOVABLE EQUIPMENT DOLLAR VALUE 2	EMPLOYEE BENEFITS GROSS SALARIES 4	RECON- CILIATION 5A.01	ADMINISTRA TIVE & ACC OUNTING ACCUM COST 5.01	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	1,658,189	1,369,328	1,815,399		1,727,621	202
203 UNIT COST MULT-WS B PT I	15.946272	0.830882	0.237082		0.093392	203
204 COST TO BE ALLOC PER B PT II			10,395		452,004	204
205 UNIT COST MULT-WS B PT II			0.001358		0.024434	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					1
2					2
4					4
5.01					5.01
5.02	42,979,827				5.02
6					6
7		54,050			7
8		880	17,033		8
9		767	839	990	9
10		2,839	95	16	7,908
11					10
12					11
13		1,592			12
14					13
14.01		1,340			14
14.02				19	14.01
15		743		22	14.02
16		1,796		14	15
17					16
19					17
20					19
21					20
22					21
23					22
30	2,720,840	5,487	9,515	391	7,908
31					30
50	2,661,757	6,069	1,913	96	31
53					50
54	4,716,934	2,896	2,104	96	53
57	7,173,971	480		9	54
58	1,501,025			1	57
60	9,724,031	6,133		75	58
62.30					60
65	2,365,980	3,241		35	62.30
66	2,142,425	5,623	728	37	65
67					66
68					67
69	747,718			4	68
71	1,617,803	960	55		69
72					71
73	2,297,611				72
76.97					73
76.98					76.97
76.99					76.98
88	874,422	1,296		39	76.99
90	603,416	787			88
90.01					90
91	3,470,053	4,421	1,784	88	90.01
92					91
99.10					92
99.20					99.10
99.30					99.20
99.40					99.30
118	42,617,986	47,350	17,033	942	7,908
190		1,040			118
192	361,841	1,979		48	190
192.01		3,681			192
					192.01

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION		BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		GROSS CHARGES	SQUARE FEET	POUNDS OF LAUNDRY	HOURS OF SERVICE	MEALS SERVED	
		5.02	7	8	9	10	
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	COST TO BE ALLOC PER B PT I	1,839,484	1,182,131	97,001	295,540	296,916	202
203	UNIT COST MULT-WS B PT I	0.042799	21.871064	5.694886	298.525253	37.546282	203
204	COST TO BE ALLOC PER B PT II	415,399	306,192	21,812	23,952	70,345	204
205	UNIT COST MULT-WS B PT II	0.009665	5.664977	1.280573	24.193939	8.895422	205

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY
	MEALS SERVED	DIRECT NRSNG HRS	COSTED REQUIS.	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	12,391				11
12 MAINTENANCE OF PERSONNEL					12
13 NURSING ADMINISTRATION	130	146,222			13
14 CENTRAL SERVICES & SUPPLY					14
14.01 PURCHASING	201		1,101,722		14.01
14.02 CENTRAL SERVICES & SUPPLY			2,813	563,917	14.02
15 PHARMACY	136		7,312		1,000
16 MEDICAL RECORDS & LIBRARY	500		3,046		15
17 SOCIAL SERVICE	100				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	3,433	71,459	64,581		30
31 INTENSIVE CARE UNIT					31
ANCILLARY SERVICE COST CENTERS					
50 OPERATING ROOM	1,112	22,577	128,471		50
53 ANESTHESIOLOGY					53
54 RADIOLOGY-DIAGNOSTIC	1,153		91,910		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	141		27,499		57
58 MAGNETIC RESONANCE IMAGING (MRI)	156		5,246		58
60 LABORATORY	1,418		625,756		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65 RESPIRATORY THERAPY	729		26,362		65
66 PHYSICAL THERAPY			12,492	978	66
67 OCCUPATIONAL THERAPY					67
68 SPEECH PATHOLOGY					68
69 ELECTROCARDIOLOGY			6,277		69
71 MEDICAL SUPPLIES CHRGD TO PATIENTS	63			562,939	71
72 IMPL. DEV. CHARGED TO PATIENT					72
73 DRUGS CHARGED TO PATIENTS					1,000
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)	836	17,436	16,946		88
90 CLINIC	267		11,880		90
90.01 SALEM MEDICAL CLINIC					90.01
91 EMERGENCY	1,669	34,750	52,477		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)	12,044	146,222	1,083,068	563,917	1,000
NONREIMBURSABLE COST CENTERS					
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN	197		5,622		190
192 PHYSICIANS' PRIVATE OFFICES	150		13,032		192
192.01 TEMPORARILY IDLE SPACE					192.01

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WORKSHEET B-1

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	CAFETERIA	NURSING ADMINIS- TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	
	MEALS SERVED 11	DIRECT NRSING HRS 13	COSTED REQUIS. 14.01	COSTED REQ UIS. 14.02	COSTED REQUIS. 15	
200 CROSS FOOT ADJUSTMENTS						200
201 NEGATIVE COST CENTER						201
202 COST TO BE ALLOC PER B PT I	439,030	184,929	194,376	6,278	1,346,756	202
203 UNIT COST MULT-WS B PT I	35.431361	1.264714	0.176429	0.011133	1,346.756000	203
204 COST TO BE ALLOC PER B PT II	10,056	38,491	33,156	547	46,428	204
205 UNIT COST MULT-WS B PT II	0.811557	0.263237	0.030095	0.000970	46.428000	205

COST ALLOCATION - STATISTICAL BASIS

COST CENTER DESCRIPTION	MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
GENERAL SERVICE COST CENTERS			1
1 CAP REL COSTS-BLDG & FIXT			2
2 CAP REL COSTS-MVBLE EQUIP			4
4 EMPLOYEE BENEFITS			5.01
5.01 ADMINISTRATIVE & ACCOUNTING			5.02
5.02 BUSINESS SERVICES			6
6 MAINTENANCE & REPAIRS			7
7 OPERATION OF PLANT			8
8 LAUNDRY & LINEN SERVICE			9
9 HOUSEKEEPING			10
10 DIETARY			11
11 CAFETERIA			12
12 MAINTENANCE OF PERSONNEL			13
13 NURSING ADMINISTRATION			14
14 CENTRAL SERVICES & SUPPLY			14.01
14.01 PURCHASING			14.02
14.02 CENTRAL SERVICES & SUPPLY			15
15 PHARMACY			16
16 MEDICAL RECORDS & LIBRARY	1,518		17
17 SOCIAL SERVICE		2,916	19
19 NONPHYSICIAN ANESTHETISTS			20
20 NURSING SCHOOL			21
21 I&R SRVCES-SALARY & FRINGES APPRVD			22
22 I&R SRVCES-OTHER PRGM COSTS APPRVD			23
23 PARAMED ED PRGM-(SPECIFY)			
INPATIENT ROUTINE SERV COST CENTERS			30
30 ADULTS & PEDIATRICS	479	2,916	31
31 INTENSIVE CARE UNIT			
ANCILLARY SERVICE COST CENTERS			50
50 OPERATING ROOM	111		53
53 ANESTHESIOLOGY			54
54 RADIOLOGY-DIAGNOSTIC	5		57
57 COMPUTED TOMOGRAPHY (CT) SCAN			58
58 MAGNETIC RESONANCE IMAGING (MRI)			60
60 LABORATORY	413		62.30
62.30 BLOOD CLOTTING FOR HEMOPHILIACS			65
65 RESPIRATORY THERAPY	76		66
66 PHYSICAL THERAPY	99		67
67 OCCUPATIONAL THERAPY			68
68 SPEECH PATHOLOGY			69
69 ELECTROCARDIOLOGY	39		71
71 MEDICAL SUPPLIES CHRGD TO PATIENTS			72
72 IMPL. DEV. CHARGED TO PATIENT			73
73 DRUGS CHARGED TO PATIENTS			76.97
76.97 CARDIAC REHABILITATION			76.98
76.98 HYPERBARIC OXYGEN THERAPY			76.99
76.99 LITHOTRIPSY			
OUTPATIENT SERVICE COST CENTERS			88
88 RURAL HEALTH CLINIC (RHC)	44		90
90 CLINIC			90.01
90.01 SALEM MEDICAL CLINIC			91
91 EMERGENCY	252		92
92 OBSERVATION BEDS			
OTHER REIMBURSABLE COST CENTERS			99.10
99.10 CORF			99.20
99.20 OUTPATIENT PHYSICAL THERAPY			99.30
99.30 OUTPATIENT OCCUPATIONAL THERAPY			99.40
99.40 OUTPATIENT SPEECH PATHOLOGY			
SPECIAL PURPOSE COST CENTERS			118
118 SUBTOTALS (SUM OF LINES 1-117)	1,518	2,916	
NONREIMBURSABLE COST CENTERS			190
190 GIFT, FLOWER, COFFEE SHOP & CANTEEN			192
192 PHYSICIANS' PRIVATE OFFICES			192.01
192.01 TEMPORALLY IDLE SPACE			

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COST ALLOCATION - STATISTICAL BASIS

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COST CENTER DESCRIPTION		MEDICAL RECORDS & LIBRARY TIME SPENT 16	SOCIAL SERVICE TIME SPENT 17	
200	CROSS FOOT ADJUSTMENTS			200
201	NEGATIVE COST CENTER			201
202	COST TO BE ALLOC PER B PT I	463,454	92,200	202
203	UNIT COST MULT-WS B PT I	305.305665	31.618656	203
204	COST TO BE ALLOC PER B PT II	74,898	2,141	204
205	UNIT COST MULT-WS B PT II	49.339921	0.734225	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	3,687,683		3,687,683		3,687,683	30
31 INTENSIVE CARE UNIT						31
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	1,827,479		1,827,479		1,827,479	50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	1,778,471		1,778,471		1,778,471	54
57 COMPUTED TOMOGRAPHY (CT) SC	628,206		628,206		628,206	57
58 MAGNETIC RESONANCE IMAGING	604,116		604,116		604,116	58
60 LABORATORY	2,831,916		2,831,916		2,831,916	60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	874,329		874,329		874,329	65
66 PHYSICAL THERAPY	1,161,567		1,161,567		1,161,567	66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	119,804		119,804		119,804	69
71 MEDICAL SUPPLIES CHRGED TO	770,767		770,767		770,767	71
72 IMPL. DEV. CHARGED TO PATIE	23,855		23,855		23,855	72
73 DRUGS CHARGED TO PATIENTS	1,445,091		1,445,091		1,445,091	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)	856,377		856,377		856,377	88
90 CLINIC	278,992		278,992		278,992	90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	2,686,138		2,686,138		2,686,138	91
92 OBSERVATION BEDS	318,144		318,144		318,144	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)	19,892,935		19,892,935		19,892,935	200
201 LESS OBSERVATION BEDS	318,144		318,144		318,144	201
202 TOTAL (SEE INSTRUCTIONS)	19,574,791		19,574,791		19,574,791	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			
30 INPATIENT ROUTINE SERV COST CENTERS						30
31 ADULTS & PEDIATRICS	2,720,840		2,720,840			31
50 INTENSIVE CARE UNIT						
53 ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	473,112	2,188,645	2,661,757	0.686569	0.686569	0.686569 50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	389,228	4,327,706	4,716,934	0.377040	0.377040	0.377040 54
57 COMPUTED TOMOGRAPHY (CT) SC	566,460	6,607,511	7,173,971	0.087567	0.087567	0.087567 57
58 MAGNETIC RESONANCE IMAGING	53,812	1,447,213	1,501,025	0.402469	0.402469	0.402469 58
60 LABORATORY	1,288,580	8,435,451	9,724,031	0.291229	0.291229	0.291229 60
62.30 BLOOD CLOTTING FOR HEMOPHIL						62.30
65 RESPIRATORY THERAPY	1,037,668	1,328,312	2,365,980	0.369542	0.369542	0.369542 65
66 PHYSICAL THERAPY	198,887	1,943,538	2,142,425	0.542174	0.542174	0.542174 66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	46,367	701,351	747,718	0.160226	0.160226	0.160226 69
71 MEDICAL SUPPLIES CHRGED TO	540,942	973,946	1,514,888	0.508795	0.508795	0.508795 71
72 IMPL. DEV. CHARGED TO PATIE	5,925	96,990	102,915	0.231793	0.231793	0.231793 72
73 DRUGS CHARGED TO PATIENTS	834,444	1,463,167	2,297,611	0.628954	0.628954	0.628954 73
76.97 CARDIAC REHABILITATION						76.97
76.98 HYPERBARIC OXYGEN THERAPY						76.98
76.99 LITHOTRIPSY						76.99
88 OUTPATIENT SERVICE COST CENTERS						88
90 RURAL HEALTH CLINIC (RHC)		874,422	874,422			88
90 CLINIC	900	602,516	603,416	0.462354	0.462354	0.462354 90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY		3,470,053	3,470,053	0.774091	0.774091	0.774091 91
92 OBSERVATION BEDS	265	203,934	204,199	1.558010	1.558010	1.558010 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)	8,157,430	34,664,755	42,822,185			200
201 LESS OBSERVATION BEDS						201
202 TOTAL (SEE INSTRUCTIONS)	8,157,430	34,664,755	42,822,185			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. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
50 ANCILLARY SERVICE COST CENTERS								
50 OPERATING ROOM	0.686569		1,306,442			896,963		50
53 ANESTHESIOLOGY								53
54 RADIOLOGY-DIAGNOSTIC	0.377040		1,909,244			719,861		54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.087567		2,658,350			232,784		57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.402469		587,145			236,308		58
60 LABORATORY	0.291229		3,448,992			1,004,446		60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65 RESPIRATORY THERAPY	0.369542		693,821			256,396		65
66 PHYSICAL THERAPY	0.542174		889,585			482,310		66
67 OCCUPATIONAL THERAPY								67
68 SPEECH PATHOLOGY								68
69 ELECTROCARDIOLOGY	0.160226		377,008			60,406		69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.508795		428,148			217,840		71
72 IMPL. DEV. CHARGED TO PATIENT	0.231793		96,990			22,482		72
73 DRUGS CHARGED TO PATIENTS	0.628954		880,132			553,563		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	0.462354		320,617			148,239		90
90.01 SALEM MEDICAL CLINIC								90.01
91 EMERGENCY	0.774091		1,194,188			924,410		91
92 OBSERVATION BEDS	1.558010		112,497			175,271		92
OTHER REIMBURSABLE COST CENTERS								
200 SUBTOTAL (SEE INSTRUCTIONS)			14,903,159			5,931,279		200
201 LESS PBP CLINIC LAB SERVICES								201
202 NET CHARGES (LINE 200 - LINE 201)			14,903,159			5,931,279		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	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. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES 5	COST SERVICES SUBJECT TO DED & COINS 6	COST SVCS NOT SUBJECT TO DED & COINS 7	
50 ANCILLARY SERVICE COST CENTERS							50	
53 OPERATING ROOM	0.686569						53	
54 ANESTHESIOLOGY							54	
57 RADIOLOGY-DIAGNOSTIC	0.377040						57	
58 COMPUTED TOMOGRAPHY (CT) SCAN	0.087567						58	
60 MAGNETIC RESONANCE IMAGING (MRI)	0.402469						60	
62.30 LABORATORY	0.291229						62.30	
65 BLOOD CLOTING FOR HEMOPHILIACS							65	
66 RESPIRATORY THERAPY	0.369542						66	
67 PHYSICAL THERAPY	0.542174						67	
68 OCCUPATIONAL THERAPY							68	
69 SPEECH PATHOLOGY							69	
71 ELECTROCARDIOLOGY	0.160226						71	
72 MEDICAL SUPPLIES CHRGD TO PATI	0.508795						72	
73 IMPL. DEV. CHARGED TO PATIENT	0.231793						73	
76.97 DRUGS CHARGED TO PATIENTS	0.628954						76.97	
76.98 CARDIAC REHABILITATION							76.98	
76.99 HYPERBARIC OXYGEN THERAPY							76.99	
88 LITHOTRIPSY							88	
90 OUTPATIENT SERVICE COST CENTERS							90	
90.01 RURAL HEALTH CLINIC (RHC)							90.01	
91 CLINIC	0.462354						91	
92 SALEM MEDICAL CLINIC							92	
EMERGENCY	0.774091						92	
OBSERVATION BEDS	1.558010						200	
200 OTHER REIMBURSABLE COST CENTERS							201	
201 SUBTOTAL (SEE INSTRUCTIONS)							201	
202 LESS PBP CLINIC LAB SERVICES							202	
NET CHARGES (LINE 200 - LINE 201)								

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
 PART I

CHECK
 APPLICABLE
 BOXES

[] TITLE V
 [] TITLE XVIII-PT A
 [XX] TITLE XIX

COST CENTER DESCRIPTION	CAP-REL COST		REDUCED	TOTAL PATIENT DAYS	PER	INPAT PGM DAYS	INPAT PGM	CAP COST
	(FROM WKST B, PT. II, COL. 26)	SWING-BED ADJUSTMENT	CAP-REL COST (COL.1 MINUS COL.2)		DIEM (COL.3 + COL.4)		(COL.5 x COL.6)	
	1	2	3	4	5	6	7	
30 INPAT ROUTINE SERV COST CTRS								30
ADULTS & PEDIATRICS	406,881	32,668	374,213	2,921	128.11	156	19,985	31
31 INTENSIVE CARE UNIT								32
32 CORONARY CARE UNIT								33
33 BURN INTENSIVE CARE UNIT								34
34 SURGICAL INTENSIVE CARE UNIT								35
35 OTHER SPECIAL CARE (SPECIFY)								40
40 SUBPROVIDER - IPF								41
41 SUBPROVIDER - IRF								42
42 SUBPROVIDER I								43
43 NURSERY								44
44 SKILLED NURSING FACILITY								45
45 NURSING FACILITY								200
200 TOTAL (LINES 30-199)	406,881		374,213	2,921		156	19,985	

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	407,995	2,661,757	0.153280				50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	353,721	4,716,934	0.074990				54
57	COMPUTED TOMOGRAPHY (CT) SCAN	90,816	7,173,971	0.012659				57
58	MAGNETIC RESONANCE IMAGING (M	404,796	1,501,025	0.269680				58
60	LABORATORY	399,201	9,724,031	0.041053				60
62.30	BLOOD CLOTTING FOR HEMOPHILIA							62.30
65	RESPIRATORY THERAPY	133,684	2,365,980	0.056503				65
66	PHYSICAL THERAPY	175,126	2,142,425	0.081742				66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	19,898	747,718	0.026612				69
71	MEDICAL SUPPLIES CHRGED TO PA	52,424	1,514,888	0.034606				71
72	IMPL. DEV. CHARGED TO PATIENT	533	102,915	0.005179				72
73	DRUGS CHARGED TO PATIENTS	68,634	2,297,611	0.029872				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)	62,267	874,422	0.071209				88
90	CLINIC	34,040	603,416	0.056412				90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	247,382	3,470,053	0.071291				91
92	OBSERVATION BEDS	38,167	204,199	0.186911				92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (SUM OF LINES 50-199)	2,488,684	40,101,345					200

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

VERSION: 2012.11
 08/21/2013 13:59

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
30 INPAT ROUTINE SERV COST CTRS					30
31 ADULTS & PEDIATRICS					31
32 INTENSIVE CARE UNIT					32
33 CORONARY CARE UNIT					33
34 BURN INTENSIVE CARE UNIT					34
35 SURGICAL INTENSIVE CARE UNIT					35
36 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)					

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

VERSION: 2012.11
 08/21/2013 13:59

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
30 ADULTS & PEDIATRICS	2,921		156		31
31 INTENSIVE CARE UNIT					32
32 CORONARY CARE UNIT					33
33 BURN INTENSIVE CARE UNIT					34
34 SURGICAL INTENSIVE CARE UNIT					35
35 OTHER SPECIAL CARE (SPECIFY)					40
40 SUBPROVIDER - IPF					41
41 SUBPROVIDER - IRF					42
42 SUBPROVIDER I					43
43 NURSERY					44
44 SKILLED NURSING FACILITY					45
45 NURSING FACILITY					200
200 TOTAL (SUM OF LINES 30-199)	2,921		156		

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

VERSION: 2012.11
 08/21/2013 13:59

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 PHYSICIAN ANESTHETIST COST 1	NURSING SCHOOL 2	ALLIED HEALTH 3	ALL OTHER MEDICAL EDUCATION COST 4	TOTAL COST (SUM OF COLS.1-4) 5	TOTAL O/P COST (SUM OF COLS.2-4) 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM						50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC						54
57 COMPUTED TOMOGRAPHY (CT) SCAN						57
58 MAGNETIC RESONANCE IMAGING (M						58
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
72 IMPL. DEV. CHARGED TO PATIENT						72
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

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
 PART IV

CHECK APPLICABLE BOXES	[] TITLE V [] TITLE XVIII-PT A [XX] TITLE XIX	[XX] HOSPITAL (14-1345) [] IPF [] IRF	[] SUB (OTHER) [] SNF [] NF	[] ICF/MR	[] PPS [] TEFRA [XX] OTHER	TOTAL CHARGES (FROM WKST C, PT. I, COL. 8) 7	RATIO OF COST TO CHARGES (COL. 5 ÷ COL. 7) 8	O/P RATIO OF COST TO CHARGES (COL. 6 ÷ COL. 7) 9	INPAT PGM PGM CHARGES 10	INPAT PGM PASS-THRU COSTS (COL. 8 x COL. 10) 11	O/P PGM CHARGES 12	O/P PGM PASS-THRU COSTS (COL. 9 x COL. 12) 13				
		ANCILLARY SERVICE COST CENTERS														
50						OPERATING ROOM	2,661,757							50		
53						ANESTHESIOLOGY								53		
54						RADIOLOGY-DIAGNOSTIC	4,716,934							54		
57						COMPUTED TOMOGRAPHY (CT) SCA	7,173,971							57		
58						MAGNETIC RESONANCE IMAGING (1,501,025							58		
60						LABORATORY	9,724,031							60		
62.30						BLOOD CLOTTING FOR HEMOPHILI								62.30		
65						RESPIRATORY THERAPY	2,365,980							65		
66						PHYSICAL THERAPY	2,142,425							66		
67						OCCUPATIONAL THERAPY								67		
68						SPEECH PATHOLOGY								68		
69						ELECTROCARDIOLOGY	747,718							69		
71						MEDICAL SUPPLIES CHRGED TO P	1,514,888							71		
72						IMPL. DEV. CHARGED TO PATIEN	102,915							72		
73						DRUGS CHARGED TO PATIENTS	2,297,611							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)	874,422							88		
90						CLINIC	603,416							90		
90.01						SALEM MEDICAL CLINIC								90.01		
91						EMERGENCY	3,470,053							91		
92						OBSERVATION BEDS	204,199							92		
						OTHER REIMBURSABLE COST CENTERS										
200						TOTAL (SUM OF LINES 50-199)	40,101,345							200		

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

VERSION: 2012.11
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICES COSTS

WORKSHEET D
 PART V

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

[] S/B-SNF
 [] S/B-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. SVCS NOT SUBJECT TO DED & COINS 4	PPS SERVICES SUBJECT TO DED & COINS 5	COST SVCS NOT SUBJECT TO DED & COINS 6
ANCILLARY SERVICE COST CENTERS						
50 OPERATING ROOM	0.686569					50
53 ANESTHESIOLOGY						53
54 RADIOLOGY-DIAGNOSTIC	0.377040					54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.087567					57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.402469					58
60 LABORATORY	0.291229					60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65 RESPIRATORY THERAPY	0.369542					65
66 PHYSICAL THERAPY	0.542174					66
67 OCCUPATIONAL THERAPY						67
68 SPEECH PATHOLOGY						68
69 ELECTROCARDIOLOGY	0.160226					69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.508795					71
72 IMPL. DEV. CHARGED TO PATIENT	0.231793					72
73 DRUGS CHARGED TO PATIENTS	0.628954					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	0.462354					90
90.01 SALEM MEDICAL CLINIC						90.01
91 EMERGENCY	0.774091					91
92 OBSERVATION BEDS	1.558010					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

WORKSHEET D-1
 PART I

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)	3,176	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,921	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,647	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	191	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)	64	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)	2,056	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)	191	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)	64	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	120.63	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)	3,687,683	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)	296,083	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,391,600	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,564,565	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,564,565	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.322485	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)	968.86	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)	3,391,600	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) 1,161.11 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 2,387,242 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) 2,387,242 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)					1,498,147 48
49 TOTAL PROGRAM INPATIENT COSTS (SEE INSTRUCTIONS)					3,885,389 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) 221,772 64
 65 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS) (TITLE XVIII ONLY) 74,311 65
 66 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (TITLE XVIII ONLY. FOR CAH, SEE INSTRUCTIONS) 296,083 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) 274 87
 88 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (LINE 27 ÷ LINE 2) 1,161.11 88
 89 OBSERVATION BED COST (LINE 87 x LINE 88) (SEE INSTRUCTIONS) 318,144 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	406,881	3,391,600	0.119967	318,144	38,167 90
91 NURSING SCHOOL COST					91
92 ALLIED HEALTH COST					92
93 ALL OTHER MEDICAL EDUCATION					93

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)	3,176	1
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING-BED AND NEWBORN DAYS)	2,921	2
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)		3
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	2,647	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	191	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)	64	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)	156	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	120.63	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)	3,687,683	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)	296,083	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,391,600	27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	2,564,565	28
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)		29
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	2,564,565	30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (LINE 27 ÷ LINE 28)	1.322485	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)	968.86	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)	3,391,600	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) 1,161.11 38
 39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (LINE 9 x LINE 38) 181,133 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) 181,133 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)					181,133 49

PASS-THROUGH COST ADJUSTMENTS
 50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (FROM WKST D, SUM OF PARTS I AND III) 19,985 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 19,985 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) 274 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

	COMPUTATION OF OBSERVATION BED PASS-THROUGH COST	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
90 CAPITAL-RELATED COST						90
91 NURSING SCHOOL COST						91
92 ALLIED HEALTH COST						92
93 ALL OTHER MEDICAL EDUCATION						93

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

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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	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(COL.1 x COL.2)	3
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS		1,990,375		30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.686569	227,274	156,039	50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.377040	272,807	102,859	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.087567	379,465	33,229	57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.402469	38,877	15,647	58
60 LABORATORY	0.291229	970,347	282,593	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.369542	815,279	301,280	65
66 PHYSICAL THERAPY	0.542174	75,647	41,014	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.160226	34,373	5,507	69
71 MEDICAL SUPPLIES CHRGED TO PATI	0.508795	331,808	168,822	71
72 IMPL. DEV. CHARGED TO PATIENT	0.231793	5,925	1,373	72
73 DRUGS CHARGED TO PATIENTS	0.628954	618,743	389,161	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	0.462354	455	210	90
90.01 SALEM MEDICAL CLINIC				90.01
91 EMERGENCY	0.774091			91
92 OBSERVATION BEDS	1.558010	265	413	92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		3,771,265	1,498,147	200
201 LESS BPB CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		3,771,265		202

INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-3

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

COST CENTER DESCRIPTION	RATIO OF COST	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS				
30 ADULTS & PEDIATRICS				30
31 INTENSIVE CARE UNIT				31
ANCILLARY SERVICE COST CENTERS				
50 OPERATING ROOM	0.686569			50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.377040	4,367	1,647	54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.087567			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.402469			58
60 LABORATORY	0.291229	38,619	11,247	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.369542	16,944	6,262	65
66 PHYSICAL THERAPY	0.542174	114,297	61,969	66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.160226	822	132	69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.508795	32,117	16,341	71
72 IMPL. DEV. CHARGED TO PATIENT	0.231793			72
73 DRUGS CHARGED TO PATIENTS	0.628954	36,663	23,059	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	0.462354			90
90.01 SALEM MEDICAL CLINIC				90.01
91 EMERGENCY	0.774091			91
92 OBSERVATION BEDS	1.558010			92
OTHER REIMBURSABLE COST CENTERS				
200 TOTAL (SUM OF LINES 50-94 AND 96-98)		243,829	120,657	200
201 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				201
202 NET CHARGES (LINE 200 MINUS LINE 201)		243,829		202

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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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	INPATIENT	INPATIENT	
	TO CHARGES	PROGRAM CHARGES	PROGRAM COSTS	
	1	2	(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	0.686569			50
53 ANESTHESIOLOGY				53
54 RADIOLOGY-DIAGNOSTIC	0.377040			54
57 COMPUTED TOMOGRAPHY (CT) SCAN	0.087567			57
58 MAGNETIC RESONANCE IMAGING (MRI)	0.402469			58
60 LABORATORY	0.291229			60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65 RESPIRATORY THERAPY	0.369542			65
66 PHYSICAL THERAPY	0.542174			66
67 OCCUPATIONAL THERAPY				67
68 SPEECH PATHOLOGY				68
69 ELECTROCARDIOLOGY	0.160226			69
71 MEDICAL SUPPLIES CHRGD TO PATI	0.508795			71
72 IMPL. DEV. CHARGED TO PATIENT	0.231793			72
73 DRUGS CHARGED TO PATIENTS	0.628954			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	0.462354			90
90.01 SALEM MEDICAL CLINIC				90.01
91 EMERGENCY	0.774091			91
92 OBSERVATION BEDS	1.558010			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

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

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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 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		4,321,408		3,918,646	1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	.01 10/05/2012	47,221	10/05/2012	108,593	3.01
	.02 12/19/2012	15,724	12/20/2012	75,329	3.02
PROGRAM	.03 03/19/2013	11,031	03/19/2013	751	3.03
TO	.04				3.04
PROVIDER	.05				3.05
	.06				3.06
	.07				3.07
	.08				3.08
	.09				3.09
	.50	NONE		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	73,976		184,673	3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)		4,395,384		4,103,319	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
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	PROGRAM TO .01			121,856	6.01
	PROVIDER PROVIDER				
	TO .02	-788,453			6.02
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)		3,606,931		4,225,175	7
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

WORKSHEET E-1
 PART I

CHECK APPLICABLE BOX:	[] HOSPITAL [] IPF [] IRF	[] SUB (OTHER) [] SNF [XX] SWING BED SNF (14-Z345)	INPATIENT PART A	PART B	MM/DD/YYYY 1	AMOUNT 2	MM/DD/YYYY 3	AMOUNT 4	
DESCRIPTION									
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER						414,383			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO.						NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.					.01 12/19/2012	2,000		NONE	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		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	2,000			3.99
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST E OR E-3, LINE AND COLUMN AS APPROPRIATE)						416,383			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	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					PROGRAM TO .01	4,525			6.01
					PROVIDER PROVIDER TO .02				6.02
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)					PROGRAM	420,908			7
8 NAME OF CONTRACTOR:						CONTRACTOR NUMBER:		NPR DATE:	8

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK [XX] HOSPITAL (14-1345) [] CAH
APPLICABLE BOX

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

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	746	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	2,056	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	12	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	2,647	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	42,822,185	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	644,314	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	1,079,270	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (SEE INSTRUCTIONS)	1,071,984	8
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH			
30	INITIAL/INTERIM HIT PAYMENT(S)	578,643	30
31	OTHER ADJUSTMENTS (SPECIFY)		31
32	BALANCE DUE PROVIDER (LINE 8 MINUS LINE 30 ± LINE 31)	493,341	32

PROVIDER CCN: 14-1345 SALEM TOWNSHIP HOSPITAL
 PERIOD FROM 04/01/2012 TO 03/31/2013

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

VERSION: 2012.11
 08/21/2013 13:59

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

WORKSHEET E-2

CHECK TITLE V SWING BED - SNF (14-2345)
 APPLICABLE 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)	299,044	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)	121,864	3
4 PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (SEE INSTRUCTIONS)		4
5 PROGRAM DAYS	255	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)	420,908	8
9 PRIMARY PAYER PAYMENTS (SEE INSTRUCTIONS)		9
10 SUBTOTAL (LINE 8 MINUS LINE 9)	420,908	10
11 DEDUCTIBLES BILLED TO PROGRAM PATIENTS (EXCLUDE AMTS APPLICABLE TO PHYSICIAN PROFESSIONAL SERVICES)		11
12 SUBTOTAL (LINE 10 MINUS LINE 11)	420,908	12
13 COINSURANCE BILLED TO PROGRAM PATIENTS (EXCLUDE COINSURANCE FOR PHYSICIAN PROFESSIONAL SERVICES)		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)	420,908	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)	420,908	19
20 INTERIM PAYMENTS	416,383	20
21 TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		21
22 BALANCE DUE PROVIDER/PROGRAM (LINE 19 MINUS THE SUM OF LINES 20 AND 21)	4,525	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	3,885,389	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (SEE INSTRUCTIONS)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (SUM OF LINES 1-3)	3,885,389	4
5	PRIMARY PAYER PAYMENTS	311	5
6	TOTAL COST (LINE 4 LESS LINE 5) (FOR CAH, SEE INSTRUCTIONS)	3,923,932	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 AND 17)	3,923,932	19
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	405,683	20
21	EXCESS REASONABLE COST (FROM LINE 16)		21
22	SUBTOTAL (LINE 19 MINUS LINE 20)	3,518,249	22
23	COINSURANCE	881	23
24	SUBTOTAL (LINE 22 MINUS LINE 23)	3,517,368	24
25	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) (SEE INSTRUCTIONS)	89,563	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	89,563	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)	56,458	27
28	SUBTOTAL (SUM OF LINES 24 AND 25 OR 26)	3,606,931	28
29	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		29
30	SUBTOTAL (LINE 28 PLUS OR MINUS LINE 29)	3,606,931	30
31	INTERIM PAYMENTS	4,395,384	31
32	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		32
33	BALANCE DUE PROVIDER/PROGRAM (LINE 30 MINUS THE SUM OF LINES 31 AND 32)	-788,453	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

	INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX
1 COMPUTATION OF NET COST OF COVERED SERVICES		
1 INPATIENT HOSPITAL SNF/NF SERVICES	181,133	1
2 MEDICAL AND OTHER SERVICES		2
3 ORGAN ACQUISITION (CERTIFIED TRANSPLANT CENTERS ONLY)		3
4 SUBTOTAL (SUM OF LINES 1, 2 AND 3)	181,133	4
5 INPATIENT PRIMARY PAYER PAYMENTS		5
6 OUTPATIENT PRIMARY PAYER PAYMENTS		6
7 SUBTOTAL (LINE 4 LESS SUM OF LINES 5 AND 6)	181,133	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)	181,133	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	181,133	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)	181,133	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)	181,133	36
37 OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)		37
38 SUBTOTAL (LINE 36 ± LINE 37)	181,133	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)	181,133	40
41 INTERIM PAYMENTS		41
42 BALANCE DUE PROVIDER/PROGRAM (LINE 40 MINUS 41)	181,133	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	4,175,598			1
2	TEMPORARY INVESTMENTS				2
3	NOTES RECEIVABLE				3
4	ACCOUNTS RECEIVABLE	6,195,684			4
5	OTHER RECEIVABLES				5
6	ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-2,148,933			6
7	INVENTORY	392,192			7
8	PREPAID EXPENSES	251,782			8
9	OTHER CURRENT ASSETS	699,115			9
10	DUE FROM OTHER FUNDS				10
11	TOTAL CURRENT ASSETS (SUM OF LINES 1-10)	9,565,438			11
FIXED ASSETS					
12	LAND	99,381			12
13	LAND IMPROVEMENTS	1,021,091			13
14	ACCUMULATED DEPRECIATION	-640,937			14
15	BUILDINGS	24,792,209			15
16	ACCUMULATED DEPRECIATION	-7,547,899			16
17	LEASEHOLD IMPROVEMENTS				17
18	ACCUMULATED AMORTIZATION				18
19	FIXED EQUIPMENT	1,927,798			19
20	ACCUMULATED DEPRECIATION	-992,208			20
21	AUTOMOBILES AND TRUCKS				21
22	ACCUMULATED DEPRECIATION				22
23	MAJOR MOVABLE EQUIPMENT	8,668,952			23
24	ACCUMULATED DEPRECIATION	-6,872,460			24
25	MINOR EQUIPMENT DEPRECIABLE				25
26	ACCUMULATED DEPRECIATION				26
27	HIT DESIGNATED ASSETS	1,079,269			27
28	ACCUMULATED DEPRECIATION	-235,469			28
29	MINOR EQUIPMENT-NONDEPRECIABLE				29
30	TOTAL FIXED ASSETS (SUM OF LINES 12-29)	21,299,727			30
OTHER ASSETS					
31	INVESTMENTS	4,213,907			31
32	DEPOSITS ON LEASES				32
33	DUE FROM OWNERS/OFFICERS				33
34	OTHER ASSETS	1,484,382			34
35	TOTAL OTHER ASSETS (SUM OF LINES 31-34)	5,698,289			35
36	TOTAL ASSETS (SUM OF LINES 11, 30 AND 35)	36,563,454			36
LIABILITIES AND FUND BALANCES					
		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
CURRENT LIABILITIES					
37	ACCOUNTS PAYABLE	971,077			37
38	SALARIES, WAGES & FEES PAYABLE	996,079			38
39	PAYROLL TAXES PAYABLE				39
40	NOTES & LOANS PAYABLE (SHORT TERM)	196,269			40
41	DEFERRED INCOME	265,799			41
42	ACCELERATED PAYMENTS				42
43	DUE TO OTHER FUNDS	589,258			43
44	OTHER CURRENT LIABILITIES	536,055			44
45	TOTAL CURRENT LIABILITIES (SUM OF LINES 37-44)	3,554,537			45
LONG-TERM LIABILITIES					
46	MORTGAGE PAYABLE	8,015,000			46
47	NOTES PAYABLE	1,722,399			47
48	UNSECURED LOANS				48
49	OTHER LONG TERM LIABILITIES				49
50	TOTAL LONG TERM LIABILITIES (SUM OF LINES 46-49)	9,737,399			50
51	TOTAL LIABILITIES (SUM OF LINES 45 AND 50)	13,291,936			51
CAPITAL ACCOUNTS					
52	GENERAL FUND BALANCE	23,271,518			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)	23,271,518			59
60	TOTAL LIABILITIES AND FUND BALANCES (SUM OF LINES 51 AND 59)	36,563,454			60

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND		SPECIFIC PURPOSE FUND		ENDOWMENT FUND		PLANT FUND		
	1	2	3	4	5	6	7	8	
1 FUND BALANCES AT BEGINNING OF PERIOD		22,262,754							1
2 NET INCOME (LOSS) (FROM WKST G-3, LINE 29)		1,008,764							2
3 TOTAL (SUM OF LINE 1 AND LINE 2)		23,271,518							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)		23,271,518							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)		23,271,518							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	2,267,177		2,267,177	2
3 SUBPROVIDER IPF				3
4 SUBPROVIDER IRF				4
5 SWING BED - SNF	156,275		156,275	5
6 SWING BED - NF				6
7 SKILLED NURSING FACILITY				7
8 NURSING FACILITY				8
9 OTHER LONG TERM CARE				9
10 TOTAL GENERAL INPATIENT CARE SERVICES (SUM OF LINES 1-9)	2,423,452		2,423,452	10
11 INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				11
12 INTENSIVE CARE UNIT	267,937		267,937	12
13 CORONARY CARE UNIT				13
14 BURN INTENSIVE CARE UNIT				14
15 SURGICAL INTENSIVE CARE UNIT				15
16 OTHER SPECIAL CARE (SPECIFY)				16
16 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (SUM OF LINES 11-15)	267,937		267,937	16
17 TOTAL INPATIENT ROUTINE CARE SERVICES (SUM OF LINES 10 AND 16)	2,691,389		2,691,389	17
18 ANCILLARY SERVICES	5,654,108		5,654,108	18
19 OUTPATIENT SERVICES		36,342,699	36,342,699	19
20 RHC		944,184	944,184	20
21 FQHC				21
22 HOME HEALTH AGENCY				22
23 AMBULANCE				23
24 ASC				24
25 HOSPICE				25
26 OTHER (SPECIFY)				26
27 TOTAL PATIENT REVENUES (SUM OF LINES 17-27) (TRANSFER COL. 3 TO WKST G-3, LINE 1)	8,345,497	37,286,883	45,632,380	27

PART II - OPERATING EXPENSES

	1	2	
29 OPERATING EXPENSES (PER WKST A, COL. 3, LINE 200)		25,059,217	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)		25,059,217	43

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION			
1	TOTAL PATIENT REVENUES (FROM WKST G-2, PART I, COL. 3, LINE 28)	45,632,380	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	20,631,515	2
3	NET PATIENT REVENUES (LINE 1 MINUS LINE 2)	25,000,865	3
4	LESS - TOTAL OPERATING EXPENSES (FROM WKST G-2, PART II, LINE 43)	25,059,217	4
5	NET INCOME FROM SERVICE TO PATIENTS (LINE 3 MINUS LINE 4)	-58,352	5
OTHER INCOME			
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	12,553	6
7	INCOME FROM INVESTMENTS		7
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	426	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	131,763	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		18
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	64,721	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PROPERTY TAX REVENUE)	243,840	24
24.01	OTHER (OTHER OPERATING INCOME (EXPENSE))	506,606	24.01
24.02	OTHER (NONCAPITAL GRANTS AND CONTRIBUTIONS)	144,647	24.02
24.03	OTHER (CAPITAL GRANTS AND CONTRIBUTIONS)	7,500	24.03
25	TOTAL OTHER INCOME (SUM OF LINES 6-24)	1,112,056	25
26	TOTAL (LINE 5 PLUS LINE 25)	1,053,704	26
27	OTHER EXPENSES (LOSS ON DISPOSITION OF EQUIPMENT)	44,940	27
28	TOTAL OTHER EXPENSES (SUM OF LINE 27 AND SUBSCRIPTS)	44,940	28
29	NET INCOME (OR LOSS) FOR THE PERIOD (LINE 26 MINUS LINE 28)	1,008,764	29

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								1
2								2
3	305,848	22,348	328,196		328,196		328,196	3
4								4
5	380	28	408		408		408	5
6								6
7								7
8								8
9								9
10	306,228	22,376	328,604		328,604		328,604	10
COSTS UNDER AGREEMENT								
11				29,293	29,293		29,293	11
12								12
13								13
14				29,293	29,293		29,293	14
OTHER HEALTH CARE COSTS								
15		16,946	16,946		16,946		16,946	15
16								16
17								17
18								18
19								19
20								20
21		16,946	16,946		16,946		16,946	21
22	306,228	39,322	345,550	29,293	374,843		374,843	22
COSTS OTHER THAN RHC/FQHC SERVICES								
23								23
24								24
25								25
26								26
27								27
28								28
FACILITY OVERHEAD								
29								29
30	132,127	18,155	150,282		150,282		150,282	30
31	132,127	18,155	150,282		150,282		150,282	31
32	438,355	57,477	495,832	29,293	525,125		525,125	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 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD 3	MINIMUM VISITS (COL.1 x COL.3) 4	GREATER OF COL. 2 OR COL. 4 5	
1	PHYSICIANS		4,200			1
2	PHYSICIAN ASSISTANTS		2,100			2
3	NURSE PRACTITIONERS	2.96	7,224	2,100	6,216	3
4	SUBTOTAL (SUM OF LINES 1-3)	2.96	7,224		6,216	7,224
5	VISITING NURSE					5
6	CLINICAL PSYCHOLOGIST					6
7	CLINICAL SOCIAL WORKER					7
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	2.96	7,224			7,224
9	PHYSICIAN SERVICES UNDER AGREEMENTS		89			89
DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WKST M-1, COL. 7, LINE 22)				374,843	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)				374,843	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)				150,282	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)				331,252	15
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)				481,534	16
17	ALLOWABLE DIRECT GME OVERHEAD (SEE INSTRUCTIONS)					17
18	SUBTRACT LINE 17 FROM LINE 16				481,534	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 x LINE 18)				481,534	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)				856,377	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)	856,377	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 15)	3,185	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	853,192	3
4	TOTAL VISITS (FROM WKST M-2, COL. 5, LINE 8)	7,224	4
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WKST M-2, COL. 5, LINE 9)	89	5
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	7,313	6
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	116.67	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)	116.67	116.67	116.67 9

CALCULATION OF SETTLEMENT

10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM CONTRACTOR RECORDS)	677	10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 x LINE 10)	78,986	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)	78,986	16
16.01	TOTAL PROGRAM CHARGES (SEE INSTRUCTIONS) (FROM CONTRACTOR'S RECORDS)	86,550	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%)	50,636	16.04
16.05	TOTAL PROGRAM COST (SEE INSTRUCTIONS)	50,636	16.05
17	PRIMARY PAYOR PAYMENTS		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	15,691	18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (SEE INSTRUCTIONS) (FROM CONTRACTOR RECORDS)	14,172	19
20	NET MEDICARE COST EXCLUDING VACCINES (SEE INSTRUCTIONS)	50,636	20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WKST M-4, LINE 16)	3,185	21
22	TOTAL REIMBURSABLE PROGRAM COST (LINE 20 PLUS LINE 21)	53,821	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)	53,821	26
27	INTERIM PAYMENTS	63,114	27
28	TENTATIVE SETTLEMENT (FOR CONTRACTOR USE ONLY)		28
29	BALANCE DUE COMPONENT/PROGRAM (LINE 26 MINUS LINES 27 AND 28)	-9,293	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.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

RHC I
 COMPONENT NO: 14-3413

WORKSHEET M-4

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)	328,604	328,604	1
2 RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000767	0.000767	2
3 PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (LINE 1 x LINE 2)	252	252	3
4 MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (FROM YOUR RECORDS)	342	548	4
5 DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 3 PLUS LINE 4)	594	800	5
6 TOTAL DIRECT COST OF THE FACILITY (FROM WKST M-1, COL. 7, LINE 22)	374,843	374,843	6
7 TOTAL OVERHEAD (FROM WKST M-2, LINE 16)	481,534	481,534	7
8 RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (LINE 5 DIVIDED BY LINE 6)	0.001585	0.002134	8
9 OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (LINE 7 x LINE 8)	763	1,028	9
10 TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (SUM OF LINES 5 AND 9)	1,357	1,828	10
11 TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (FROM YOUR RECORDS)	5	37	11
12 COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (LINE 10/ LINE 11)	271.40	49.41	12
13 NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	5	37	13
14 PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (LINE 12 x LINE 13)	1,357	1,828	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).		3,185	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)		3,185	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		82,087	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.		NONE	3.01
	.01		3.02
	.02		3.03
	PROGRAM .03		3.04
	TO .04		3.05
	PROVIDER .05		3.06
	.06		3.07
	.07		3.08
	.08		3.09
	.09		3.50
	.50		3.51
	.51 12/19/2012	16,720	3.52
	PROVIDER .52 03/19/2013	2,253	3.53
	TO .53		3.54
	PROGRAM .54		3.55
	.55		3.56
	.56		3.57
	.57		3.58
	.58		3.59
	.59		3.99
	.99		
SUBTOTAL (SUM OF LINES 3.01-3.49 MINUS SUM OF LINES 3.50-3.98)		-18,973	
4 TOTAL INTERIM PAYMENTS (SUM OF LINES 1, 2 AND 3.99) (TRANSFER TO WKST M-3, LINE 27)		63,114	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.		NONE	5.01
	PROGRAM .01		5.02
	TO .02		5.03
	PROVIDER .03		5.04
	.04		5.05
	.05		5.06
	.06		5.07
	.07		5.08
	.08		5.09
	.09		5.50
	PROVIDER .50	NONE	5.51
	TO .51		5.52
	PROGRAM .52		5.53
	.53		5.54
	.54		5.55
	.55		5.56
	.56		5.57
	.57		5.58
	.58		5.59
	.59		5.99
	.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 (SEE INSTR.			6.01
	PROGRAM .01		6.02
	TO .02		
	PROVIDER .02	-9,293	
	TO .02		
	PROGRAM		
		53,821	7
7 TOTAL MEDICARE PROGRAM LIABILITY (SEE INSTR.)			
8 NAME OF CONTRACTOR:		CONTRACTOR NUMBER:	NPR 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	70.39		5.34				75.73 30
UTILIZATION PERCENTAGES BASED ON CHARGES							
50 OPERATING ROOM	8.54	49.08					57.62 50
54 RADIOLOGY-DIAGNOSTIC	5.78	40.48					46.26 54
57 COMPUTED TOMOGRAPHY (CT) SCAN	5.29	37.06					42.35 57
58 MAGNETIC RESONANCE IMAGING (MRI)	2.59	39.12					41.71 58
60 LABORATORY	9.98	35.47					45.45 60
65 RESPIRATORY THERAPY	34.46	29.32					63.78 65
66 PHYSICAL THERAPY	3.53	41.52					45.05 66
69 ELECTROCARDIOLOGY	4.60	50.42					55.02 69
71 MEDICAL SUPPLIES CHRGED TO PATI	21.90	28.26					50.16 71
72 IMPL. DEV. CHARGED TO PATIENT	5.76	94.24					100.00 72
73 DRUGS CHARGED TO PATIENTS	26.93	38.31					65.24 73
90 CLINIC	0.08	53.13					53.21 90
91 EMERGENCY		34.41					34.41 91
92 OBSERVATION BEDS	0.13	55.09					55.22 92
200 TOTAL CHARGES	9.40	37.16					46.56 200

***** 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	0.09						0.09	54
60 LABORATORY	0.40						0.40	60
65 RESPIRATORY THERAPY	0.72						0.72	65
66 PHYSICAL THERAPY	5.33						5.33	66
69 ELECTROCARDIOLOGY	0.11						0.11	69
71 MEDICAL SUPPLIES CHRGED TO PATI	2.12						2.12	71
73 DRUGS CHARGED TO PATIENTS	1.60						1.60	73
200 TOTAL CHARGES	0.61						0.61	200

	COST CENTER	--- DIRECT COSTS ---		-- ALLOCATED OVERHEAD --		--- TOTAL COSTS ---		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,658,189	8.20	-1,658,189	-15.99			1
2	CAP REL COSTS-MVBLE EQUIP	1,369,328	6.77	-1,369,328	-13.21			2
3	OTHER CAPITAL RELATED COSTS							3
4	EMPLOYEE BENEFITS	1,805,004	8.92	-1,805,004	-17.41			4
5.01	ADMINISTRATIVE & ACCOUNTING	1,136,368	5.62	-1,136,368	-10.96			5.01
5.02	BUSINESS SERVICES	1,164,748	5.76	-1,164,748	-11.23			5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	751,803	3.72	-751,803	-7.25			7
8	LAUNDRY & LINEN SERVICE	49,025	0.24	-49,025	-0.47			8
9	HOUSEKEEPING	207,174	1.02	-207,174	-2.00			9
10	DIETARY	145,111	0.72	-145,111	-1.40			10
11	CAFETERIA	358,764	1.77	-358,764	-3.46			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	90,493	0.45	-90,493	-0.87			13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING	102,370	0.51	-102,370	-0.99			14.01
14.02	CENTRAL SERVICES & SUPPLY	101		-101				14.02
15	PHARMACY	1,182,967	5.85	-1,182,967	-11.41			15
16	MEDICAL RECORDS & LIBRARY	278,649	1.38	-278,649	-2.69			16
17	SOCIAL SERVICE	67,264	0.33	-67,264	-0.65			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	1,783,218	8.82	1,904,465	18.37	3,687,683	18.23	30
31	INTENSIVE CARE UNIT							31
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	852,155	4.21	975,324	9.41	1,827,479	9.04	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	912,125	4.51	866,346	8.36	1,778,471	8.79	54
57	COMPUTED TOMOGRAPHY (CT) SCAN	243,426	1.20	384,780	3.71	628,206	3.11	57
58	MAGNETIC RESONANCE IMAGING (MRI)	90,779	0.45	513,337	4.95	604,116	2.99	58
60	LABORATORY	1,484,738	7.34	1,347,178	12.99	2,831,916	14.00	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	440,405	2.18	433,924	4.19	874,329	4.32	65
66	PHYSICAL THERAPY	727,071	3.59	434,496	4.19	1,161,567	5.74	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	49,112	0.24	70,692	0.68	119,804	0.59	69
71	MEDICAL SUPPLIES CHRGD TO PATI	595,149	2.94	175,618	1.69	770,767	3.81	71
72	IMPL. DEV. CHARGED TO PATIENT	21,817	0.11	2,038	0.02	23,855	0.12	72
73	DRUGS CHARGED TO PATIENTS			1,445,091	13.94	1,445,091	7.14	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88	RURAL HEALTH CLINIC (RHC)	525,125	2.60	331,252	3.20	856,377	4.23	88
90	CLINIC	155,781	0.77	123,211	1.19	278,992	1.38	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	1,708,763	8.45	977,375	9.43	2,686,138	13.28	91
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	106,410	0.53	75,976	0.73	182,386	0.90	190
192	PHYSICIANS' PRIVATE OFFICES	162,881	0.81	161,568	1.56	324,449	1.60	192
192.01	TEMPORARILY IDLE SPACE			144,687	1.40	144,687	0.72	192.01
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	20,226,313	100.00			20,226,313	100.00	202

**** 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)