SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

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. [X] Electronically filed cost report Date: 08/27/2015 Time: 11:39 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted the cost report 4. [F] Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ___ 12. [ ] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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 WERE 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 certification 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 04/01/2014 and ending 03/31/2015, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

			TITLE XVIII				
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-316,205	-273,657	1	53,898	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		161,698				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			-12,575			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-154,507	-286,232	1	53,898	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 resopnd 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.
Please do not send appilcations, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any corresponence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

1	Street: 1201 RICKER DRIVE	P.O. Box:		1
2	City: SALEM	State: IL	ZIP Code: 62881	County: MARION 2

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	SALEM TOWNSHIP HOSPITAL	14-1345	16460	1	07 / 01 / 1966	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	SALEM S/B SNF	14-Z345	16460		12 / 17 / 1986	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	SALEM HOME HEALTH AGENCY	14-7429	16460		08 / 01 / 1985	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	PHOTOS RURAL HEALTH CLINIC	14-3413	16460		07 / 29 / 1996	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2014	To: 03 / 31 / 2015	20
21	Type of control (see instructions)	12		21

	Inpatient PPS Information	1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or '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
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
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

		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 days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							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 of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40

		V	XVIII	XIX	
Prospective Payment System (PPS)-Capital		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services ad defined in CMS Pub 15-1, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.)(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathci FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.

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 reseived 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 Nonprovider Settings

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in oolumn 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				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. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
65							65

	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66

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. 3/ col. 3 + col. 4))	
		1	2	3	4	5	
67							67

Inpatient Psychiatric Faciltiy PPS		1	2	3	
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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				71

Inpatient Rehabilitation Facility PPS		1	2	3	
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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				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
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

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.			86

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
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	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

		1	2	
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? (see instructions)	Y		106
107	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. (see instructions) If yes, the GME elinination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	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

		Physical	Occupational	Speech	Respiratory	
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.	Y	Y	Y	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 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 Pub. 15-I, Section 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
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	214,921			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 high cost 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 cetfified 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 cetfified 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

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WORKSHEET S-2
PART I

All Providers

		1	2	
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 (see instructions)	N		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 the 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				
		Part A	Part B	Title V	Title XIX	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N	N	N	160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N	165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)		166

	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 is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1			168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)				169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		10 / 01 / 2013	09 / 30 / 2014	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N	171

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation		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	
		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

		Y/N	Type	Date	
Financial Data and Reports		1	2	3	
4	Column 1: Were the financial statements prepared by a Certified Public Accnountant? 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	07/27/2015	4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities		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 instructinos.	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

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		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	06/16/2015	Y	06/16/2015	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 Reoprt 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 HOSPITAL 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 relifed 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 capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.	Y	29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	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

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
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 servcies to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

						Inpatient Days / Outpatient Visits / Trips				
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	48,288.00		1,432	39	2,012	1
2	HMO and other (see instructions)						71			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						488		488	5
6	Hospital Adults & Peds. Swing Bed NF								94	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	48,288.00		1,920	39	2,594	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)		25	9,125	48,288.00		1,920	39	2,594	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
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					1,209		9,640	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								337	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

		Full Time Equivalents			DISCHARGES				
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					397	39	556	1
2	HMO and other (see instructions)					22			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								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 instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		177.22			397	39	556	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		11.06						26
27	Total (sum of lines 14-26)		188.28						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA **HHA CCN: 14-7429** **WORKSHEET S-4**

HOME HEALTH AGENCY STATISTICAL DATA County:

		Title V	Title XVIII	Title XIX	Other	Total	
	Description	1	2	3	4	5	
1	Home Health Aide Hours						1
2	Unduplicated Census Count (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
3	Administrator and Assistant Administrator(s)				3
4	Director(s) and Assistant Director(s)				4
5	Other Administrative Personnel				5
6	Direct Nursing Service				6
7	Nursing Supervisor				7
8	Physical Therapy Service				8
9	Physical Therapy Supervisor				9
10	Occupational Therapy Service				10
11	Occupational Therapy Supervisor				11
12	Speech Pathology Service				12
13	Speech Pathology Supervisor				13
14	Medical Social Service				14
15	Medical Social Service Supervisor				15
16	Home Health Aide				16
17	Home Health Aide Supervisor				17
18	Other (specify)				18

HOME HEALTH AGENCY CBSA CODES

19	Enter the number of CBSAs where you provided services during the cost reporting period.	1	19
20	List those CBSA code(s) serviced during this cost reporting period (line 20 contains the first code).	16460	20

PPS ACTIVITY

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP only Episodes	Total (columns 1 through 4)	
		1	2	3	4	5	
21	Skilled Nursing Visits						21
22	Skilled Nursing Visit Charges						22
23	Physical Therapy Visits						23
24	Physical Therapy Visit Charges						24
25	Occupational Therapy Visits						25
26	Occupational Therapy Visit Charges						26
27	Speech Pathology Visits						27
28	Speech Pathology Visit Charges						28
29	Medical Social Service Visits						29
30	Medical Social Service Visit Charges						30
31	Home Health Aide Visits						31
32	Home Health Aide Visit Charges						32
33	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)						33
34	Other Charges						34
35	Total Charges (sum of lines 22, 24, 26, 28, 30, 32 and 34)						35
36	Total Number of Episodes (standard/non-outlier)						36
37	Total Number of Ourlier Episodes						37
38	Total Non-Routine Medical Supply Charges						38

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

		Y/N	DATE	
		1	2	
1	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter 'Y' for yes and do not complete the rest of this worksheet.	N		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	/ /	2

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
3	RUX				3
4	RUL				4
5	RVX				5
6	RVL				6
7	RHX				7
8	RHL				8
9	RMX				9
10	RML				10
11	RLX				11
12	RUC				12
13	RUB				13
14	RUA				14
15	RVC				15
16	RVB				16
17	RVA				17
18	RHC				18
19	RHB				19
20	RHA				20
21	RMC				21
22	RMB				22
23	RMA				23
24	RLB				24
25	RLA				25
26	ES3				26
27	ES2				27
28	ES1				28
29	HE2				29
30	HE1				30
31	HD2				31
32	HD1				32
33	HC2				33
34	HC1				34
35	HB2				35
36	HB1				36
37	LE2				37
38	LE1				38
39	LD2				39
40	LD1				40
41	LC2				41
42	LC1				42
43	LB2				43
44	LB1				44
45	CE2				45
46	CE1				46
47	CD2				47
48	CD1				48
49	CC2				49
50	CC1				50
51	CB2				51
52	CB1				52
53	CA2				53
54	CA1				54
55	SE3				55
56	SE2				56
57	SE1				57
58	SSC				58
59	SSB				59
60	SSA				60
61	IB2				61
62	IB1				62
63	IA1				63
64	IA2				64
65	BB2				65
66	BB1				66
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA **WORKSHEET S-7**

	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1	2	3	4	
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1	2	
201	Enter in column 1 the SNF CBSA code, or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2 the code in effect on or after October 1 of the cost reporting period (if applicable).			201

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each catetory. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter 'Y' or 'N' for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1	2	3	
202	Staffing				202
203	Recruitment				203
204	Retention of employees				204
205	Training				205
206	Other (specify)				206
207	Total SNF Revenue (Worksheet G-2, Part I, line 7, column 3)				207

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER **COMPONENT CCN: 14-3413** **WORKSHEET S-8**
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 the Homeless (Section 340(d), PHS			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
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.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic	0900	1830	0900	1830	0900	1830	0900	1830	0900	1830	0900	1830	0900	1830	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.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	Provider name: CCN number:			14

		Y/N	V	XVIII	XIX	Total Visits	
		1	2	3	4	5	
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 by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA **WORKSHEET S-10**

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.396445	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	1,742,676	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	1,042,381	5
6	Medicaid charges	8,082,763	6
7	Medicaid cost (line 1 times line 6)	3,204,371	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.	419,314	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 fundnig 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)	419,314	19

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		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	157,049	98,065	255,114	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	62,261	38,877	101,138	21
22	Partial payment by patients approved for charity care	24,549	29,597	54,146	22
23	Cost of charity care (line 21 minus line 22)	37,712	9,280	46,992	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)	1,421,601	26
27	Medicare bad debts for the entire hospital complex (see instructions)	322,392	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,099,209	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	435,776	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	482,768	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	902,082	31

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI-FICATIONS	RECLASSI-FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOC-ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		1,121,333	1,121,333	430,301	1,551,634		1,551,634	1
2	00200	Cap Rel Costs-Mvble Equip		637,930	637,930	844,225	1,482,155	-209,960	1,272,195	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	115,827	2,227,269	2,343,096		2,343,096	-69,000	2,274,096	4
5.01	00592	ADMINISTRATIVE & ACCOUNTING	804,267	1,588,947	2,393,214	-437,512	1,955,702	-334,912	1,620,790	5.01
5.02	00591	BUSINESS SERVICES	425,376	308,955	734,331	-3,775	730,556	-43,131	687,425	5.02
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	242,134	508,311	750,445	-5,749	744,696		744,696	7
8	00800	Laundry & Linen Service	29,132	21,281	50,413		50,413		50,413	8
9	00900	Housekeeping	99,919	71,613	171,532		171,532		171,532	9
10	01000	Dietary	261,003	415,435	676,438	-503,584	172,854	-30,635	142,219	10
11	01100	Cafeteria				502,574	502,574	-117,479	385,095	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	123,140	14,718	137,858		137,858		137,858	13
14	01400	Central Services & Supply								14
14.01	01401	PURCHASING	94,410	14,234	108,644		108,644		108,644	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	15,395	462,463	477,858	-477,858				14.02
15	01500	Pharmacy	45,126	1,150,611	1,195,737		1,195,737	-107	1,195,630	15
16	01600	Medical Records & Library	174,439	145,478	319,917	-2,065	317,852		317,852	16
17	01700	Social Service	55,899	9,297	65,196		65,196		65,196	17
19	01900	Nonphysician Anesthetists				530,000	530,000	-530,000		19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,829,582	467,926	2,297,508	161,559	2,459,067	-422,690	2,036,377	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	625,733	536,278	1,162,011	-170,976	991,035	-87,250	903,785	50
53	05300	Anesthesiology		526,423	526,423	-526,423				53
54	05400	Radiology-Diagnostic	565,847	436,614	1,002,461	-48,826	953,635		953,635	54
57	05700	CT Scan	78,763	153,186	231,949		231,949		231,949	57
58	05800	MRI	96,906	471,164	568,070	-454,800	113,270		113,270	58
60	06000	Laboratory	597,362	1,365,696	1,963,058	-312,092	1,650,966		1,650,966	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	314,102	193,852	507,954	-8,474	499,480	-53,088	446,392	65
66	06600	Physical Therapy		799,986	799,986	-770	799,216		799,216	66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology	89,633	7,981	97,614		97,614	-45,597	52,017	69
71	07100	Medical Supplies Charged to Patients				477,858	477,858		477,858	71
72	07200	Impl. Dev. Charged to Patients		213,492	213,492		213,492		213,492	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	633,268	270,050	903,318	-155,097	748,221		748,221	88
90	09000	Clinic	167,603	28,829	196,432	-5,035	191,397		191,397	90
90.01	09001	SALEM MEDICAL CLINIC								90.01
91	09100	Emergency	938,160	2,104,496	3,042,656	-55,381	2,987,275	-1,217,335	1,769,940	91
92	09200	Observation Beds (Non-Distinct Part)								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)	8,423,026	16,273,848	24,696,874	-221,900	24,474,974	-3,161,184	21,313,790	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	49,006	54,778	103,784		103,784		103,784	190
192	19200	Physicians' Private Offices	53,621	6,879	60,500	-95	60,405		60,405	192
192.01	19201	TEMPORAILY IDLE SPACE								192.01
192.02	19202	STH FAM HLTH CRT	650,538	186,518	837,056	221,995	1,059,051		1,059,051	192.02
200		TOTAL (sum of lines 118-199)	9,176,191	16,522,023	25,698,214		25,698,214	-3,161,184	22,537,030	200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

RECLASSIFICATIONS **WORKSHEET A-6**

			INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COST	A	Cafeteria	11	193,918	308,656	1
500	Total reclassifications				193,918	308,656	500
	Code Letter - A						
1	TO RECLASSIFY SUPPLY COST	B	Medical Supplies Charged to P	71	15,395	462,463	1
500	Total reclassifications				15,395	462,463	500
	Code Letter - B						
1	TO RECLASS RENTALS	C	Cap Rel Costs-Mvble Equip	2		844,225	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
16							16
17							17
500	Total reclassifications					844,225	500
	Code Letter - C						
1	TO RECLASS CRNA COST	D	Nonphysician Anesthetists	19		530,000	1
500	Total reclassifications					530,000	500
	Code Letter - D						
1	TO RECLASS REMAINING ANESTHESIA SUPP	E	Anesthesiology	53		3,577	1
500	Total reclassifications					3,577	500
	Code Letter - E						
1	TO RECLASS INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		341,827	1
500	Total reclassifications					341,827	500
	Code Letter - F						
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G	Rural Health Clinic	88		36,034	1
500	Total reclassifications					36,034	500
	Code Letter - G						
1	TO RECLASS OTHER CAPITAL COSTS	H	Cap Rel Costs-Bldg & Fixt	1		88,474	1
500	Total reclassifications					88,474	500
	Code Letter - H						
1	RECLASS THE REF LAB TO FHCC	J	STH FAM HLTH CRT	192.02		227,078	1
500	Total reclassifications					227,078	500
	Code Letter - J						
1	RECLASS HOSPITALIST SERVICES	K	Adults & Pediatrics	30	30,833	158,020	1
500	Total reclassifications				30,833	158,020	500
	Code Letter - K						
	GRAND TOTAL (Increases)				240,146	3,000,354	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

RECLASSIFICATIONS **WORKSHEET A-6**

			DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	TO RECLASS CAFETERIA COST	A	Dietary	10	193,918	308,656		1
500	Total reclassifications				193,918	308,656		500
	Code letter - A							
1	TO RECLASSIFY SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	14.02	15,395	462,463		1
500	Total reclassifications				15,395	462,463		500
	Code letter - B							
1	TO RECLASS RENTALS	C	ADMINISTRATIVE & ACCOUNTING	5.01		7,211	10	1
2			BUSINESS SERVICES	5.02		3,775		2
3			Operation of Plant	7		5,749		3
4			Dietary	10		1,010		4
5			Medical Records & Library	16		2,065		5
6			Adults & Pediatrics	30		27,294		6
7			Operating Room	50		167,399		7
8			Radiology-Diagnostic	54		48,826		8
9			MRI	58		454,800		9
10			Laboratory	60		85,014		10
11			Respiratory Therapy	65		8,474		11
12			Physical Therapy	66		770		12
13			Rural Health Clinic	88		2,278		13
14			Clinic	90		5,035		14
15			Emergency	91		19,347		15
16			Physicians' Private Offices	192		95		16
17			STH FAM HLTH CRT	192.02		5,083		17
500	Total reclassifications					844,225		500
	Code letter - C							
1	TO RECLASS CRNA COST	D	Anesthesiology	53		530,000		1
500	Total reclassifications					530,000		500
	Code letter - D							
1	TO RECLASS REMAINING ANESTHESIA SUPP	E	Operating Room	50		3,577		1
500	Total reclassifications					3,577		500
	Code letter - E							
1	TO RECLASS INTEREST EXPENSE	F	ADMINISTRATIVE & ACCOUNTING	5.01		341,827	14	1
500	Total reclassifications					341,827		500
	Code letter - F							
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G	Emergency	91		36,034		1
500	Total reclassifications					36,034		500
	Code letter - G							
1	TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	5.01		88,474	14	1
500	Total reclassifications					88,474		500
	Code letter - H							
1	RECLASS THE REF LAB TO FHCC	J	Laboratory	60		227,078		1
500	Total reclassifications					227,078		500
	Code letter - J							
1	RECLASS HOSPITALIST SERVICES	K	Rural Health Clinic	88	30,833	158,020		1
500	Total reclassifications				30,833	158,020		500
	Code letter - K							
	GRAND TOTAL (Decreases)				240,146	3,000,354		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

			Acquisitions						
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	99,382	35,374		35,374		134,756		1
2	Land Improvements	1,140,199	20,747		20,747		1,160,946		2
3	Buildings and Fixtures	31,003,545	6,484,783		6,484,783	591,596	36,896,732		3
4	Building Improvements								4
5	Fixed Equipment	2,037,664	64,207		64,207		2,101,871		5
6	Movable Equipment	8,970,351	139,016		139,016	243,599	8,865,768		6
7	HIT-designated Assets	1,079,269					1,079,269		7
8	Subtotal (sum of lines 1-7)	44,330,410	6,744,127		6,744,127	835,195	50,239,342		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	44,330,410	6,744,127		6,744,127	835,195	50,239,342		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,121,333						1,121,333	1
2	Cap Rel Costs-Mvble Equip	637,930						637,930	2
3	Total (sum of lines 1-2)	1,759,263						1,759,263	3

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
2	Cap Rel Costs-Mvble Equ				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,121,333					430,301	1,551,634	1
2	Cap Rel Costs-Mvble Equip	637,930	844,225				-209,960	1,272,195	2
3	Total (sum of lines 1-2)	1,759,263	844,225				220,341	2,823,829	3

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

ADJUSTMENTS TO EXPENSES **WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	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	-2,115	ADMINISTRATIVE & ACCOUNTING	5.01		3
4	Trace, 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	-1,383	BUSINESS SERVICES	5.02		7
8	Television and radio service (chapter 21)	A	-1,903	ADMINISTRATIVE & ACCOUNTING	5.01		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,825,960				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	-117,479	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	-107	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 overpayments						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			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist		-530,000	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	B	-200,052	Cap Rel Costs-Mvble Equip	2	14	32
33	TELEPHONE	A	-2,389	BUSINESS SERVICES	5.02		33
34	DIETARY REVENUE	B	-30,635	Dietary	10		34
35	BUS OFFICE COSTS ASSOC W/ PHYS CHG	A	-39,359	BUSINESS SERVICES	5.02		35
36	TELEPHONE	A	-120	ADMINISTRATIVE & ACCOUNTING	5.01	14	36
37	PHYSICIAN RECRUITMENT	A	-9,183	ADMINISTRATIVE & ACCOUNTING	5.01		37
38	OTHER REVENUE	B	-8	ADMINISTRATIVE & ACCOUNTING	5.01		38
39	LOBBYING PORTION OF DUES	A	-15,527	ADMINISTRATIVE & ACCOUNTING	5.01		39
40	MARKETING	A	-69,000	Employee Benefits Department	4		40
41	OTHER REVENUE	B	-580	ADMINISTRATIVE & ACCOUNTING	5.01		41
42	SPOUSE MEAL COST	A	-1,597	ADMINISTRATIVE & ACCOUNTING	5.01		42
43	GOODWILL AMORTIZATION- PHY. CLINIC	A	-303,879	ADMINISTRATIVE & ACCOUNTING	5.01		43
44	IMPAIRED ASSETS	A	-9,908	Cap Rel Costs-Mvble Equip	2	14	44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,161,184				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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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 CLAIMED HOME OFFICE COSTS:

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors 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.

				Related Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun-eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	50	Operating Room OR	87,250	87,250						1
2	60	Laboratory LABORATORY	66,680		66,680					2
3	65	Respiratory Therapy RESPIRATORY THE	890	890						3
4	65	Respiratory Therapy RESPIRATORY THE	52,198	52,198						4
5	69	Electrocardiology ELECTROCARDIOLO	45,597	45,597						5
6	91	Emergency EMERGENCY	1,879,183	1,217,335	661,848					6
7	30	Adults & Pediatrics HOSPITALIST	600,710	422,690	20,000					7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,732,508	1,825,960	748,528					200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

PROVIDER-BASED PHYSICIANS ADJUSTMENTS **WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	50	Operating Room OR							87,250	1
2	60	Laboratory LABORATORY								2
3	65	Respiratory Therapy RESPIRATORY THE							890	3
4	65	Respiratory Therapy RESPIRATORY THE							52,198	4
5	69	Electrocardiology ELECTROCARDIOLO							45,597	5
6	91	Emergency EMERGENCY							1,217,335	6
7	30	Adults & Pediatrics HOSPITALIST							422,690	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,825,960	200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					24	1
2	Line 1 multiplied by 15 hours per week					360	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.75	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		1,198.75				9
10	AHSEA (see instructions)		74.40				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.20	37.20				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	89,187	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	89,187	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	89,187	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	89,187	23

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

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [XX] Occupational [ ] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	89,187	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	89,187	63
64	Total cost of outside supplier services (from provider records)	62,314	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					24	1
2	Line 1 multiplied by 15 hours per week					360	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.75	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		3,582.00		3,792.50		9
10	AHSEA (see instructions)		78.51		18.90		10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	39.26	39.26				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	281,223	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	281,223	17
18	Aides (column 4, line 9 times column 4, line 10)	71,678	18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	352,901	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)		22
23	Total salary equivalency (see instructions)	352,901	23

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

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [XX] Physical [ ] Respiratory [ ] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	352,901	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	352,901	63
64	Total cost of outside supplier services (from provider records)	265,778	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS **WORKSHEET A-8-3 PARTS I-IV**

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					10	1
2	Line 1 multiplied by 15 hours per week					150	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.75	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		100.00				9
10	AHSEA (see instructions)		71.50				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.75	35.75				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	7,150	15
16	Assistants (column 3, line 9 times column 3, line 10)		16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	7,150	17
18	Aides (column 4, line 9 times column 4, line 10)		18
19	Trainees (column 5, line 9 times column 5, line 10)		19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	7,150	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.		
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	71.50	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	10,725	22
23	Total salary equivalency (see instructions)	10,725	23

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

Standard Travel Allowance			
24	Therapists (line 3 times column 2, line 11)		24
25	Assistants (line 4 times column 3, line 11)		25
26	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26
27	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		27
28	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		28
Optional Travel Allowance and Optional Travel Expense			
29	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		29
30	Assistants (column 3, line 10 times column 3, line 12)		30
31	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		31
32	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		32
33	Standard travel allowance and standard travel expense (line 28)		33
34	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		34
35	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		35

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

Standard Travel Expense			
36	Therapists (line 5 times column 2, line 11)		36
37	Assistants (line 6 times column 3, line 11)		37
38	Subtotal (sum of lines 36 and 37)		38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)		39
Optional Travel Allowance and Optional Travel Expense			
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)		40
41	Assistants (column 3, line 9 times column 3, line 10)		41
42	Subtotal (sum of lines 40 and 41)		42
43	Optoinal travel expense (line 8 times the sum of columns 1-3, line 13)		43
Total Travel Allowance and Travel Expense - Offsite Services: Complete one of the following three lines 44, 45, OR 46, as appropriate.			
44	Standard travel allowance and standard travel expense (sum of lines 38 and 39) (see instructions)		44
45	Optional travel allowance and standard travel expense (sum of lines 39 and 42) (see instructions)		45
46	Optional travel allowance and optional travel expense (sum of lines 42 and 43) (see instructions)		46

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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

Check applicable box: [ ] Occupational [ ] Physical [ ] Respiratory [XX] Speech Pathology

PART V - OVERTIME COMPUTATION

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtiem hours worked during reporting period (if column 5, line 47 is zero or equal to or greater thn 2,080, do not complete lines 48-55 and enter zero in each column of line 56						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked incolumn 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overimte already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	10,725	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	10,725	63
64	Total cost of outside supplier services (from provider records)	4,040	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & ACCOUNTING	
		0	1	2	4	4A	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,551,634	1,551,634					1
2	Cap Rel Costs-Mvble Equip	1,272,195		1,272,195				2
4	Employee Benefits Department	2,274,096	8,178	1,311	2,283,585			4
5.01	ADMINISTRATIVE & ACCOUNTING	1,620,790	338,941	16,955	160,319	2,137,005	2,137,005	5.01
5.02	BUSINESS SERVICES	687,425	91,267	188,283	149,601	1,116,576	116,967	5.02
6	Maintenance & Repairs							6
7	Operation of Plant	744,696	178,939	23,286	61,028	1,007,949	105,588	7
8	Laundry & Linen Service	50,413	12,761		7,342	70,516	7,387	8
9	Housekeeping	171,532	11,122	28	25,184	207,866	21,775	9
10	Dietary	142,219	41,168	2,468	16,908	202,763	21,240	10
11	Cafeteria	385,095			48,875	433,970	45,461	11
12	Maintenance of Personnel							12
13	Nursing Administration	137,858	5,800	654	31,036	175,348	18,369	13
14	Central Services & Supply							14
14.01	PURCHASING	108,644	19,431	401	23,795	152,271	15,951	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy	1,195,630	12,326	379	11,374	1,219,709	127,771	15
16	Medical Records & Library	317,852	26,043	5,062	43,966	392,923	41,161	16
17	Social Service	65,196			14,089	79,285	8,306	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,036,377	79,565	64,473	468,902	2,649,317	277,530	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	903,785	87,352	207,913	157,710	1,356,760	142,127	50
53	Anesthesiology							53
54	Radiology-Diagnostic	953,635	41,994	166,003	142,617	1,304,249	136,627	54
57	CT Scan	231,949	6,960	3,026	19,852	261,787	27,423	57
58	MRI	113,270		390,373	24,424	528,067	55,318	58
60	Laboratory	1,650,966	88,933	104,484	150,560	1,994,943	208,980	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	446,392	48,534	18,035	79,167	592,128	62,028	65
66	Physical Therapy	799,216	81,537	4,631		885,384	92,748	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	52,017		5,177	22,591	79,785	8,358	69
71	Medical Supplies Charged to Patients	477,858	13,921	355	3,880	496,014	51,960	71
72	Impl. Dev. Charged to Patients	213,492				213,492	22,364	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	748,221	32,322	5,641	151,838	938,022	98,262	88
90	Clinic	191,397	8,468	7,418	42,243	249,526	26,139	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	1,769,940	47,504	35,803	236,455	2,089,702	218,907	91
92	Observation Beds (Non-Distinct Part)							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)	21,313,790	1,283,066	1,252,159	2,093,756	20,835,357	1,958,747	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	103,784	15,081	4,493	12,352	135,710	14,216	190
192	Physicians' Private Offices	60,405	3,901	2,542	13,515	80,363	8,418	192
192.01	TEMPORAILY IDLE SPACE		195,948			195,948	20,527	192.01
192.02	STH FAM HLTH CRT	1,059,051	53,638	13,001	163,962	1,289,652	135,097	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,537,030	1,551,634	1,272,195	2,283,585	22,537,030	2,137,005	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		5.02	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES	1,233,543						5.02
6	Maintenance & Repairs							6
7	Operation of Plant		1,113,537					7
8	Laundry & Linen Service		15,208	93,111				8
9	Housekeeping		13,256	7,620	250,517			9
10	Dietary		49,065	637	5,091	278,796		10
11	Cafeteria						479,431	11
12	Maintenance of Personnel							12
13	Nursing Administration		6,913				5,869	13
14	Central Services & Supply							14
14.01	PURCHASING		23,158				7,022	14.01
14.02	CENTRAL SERVICES & SUPPLY				5,359			14.02
15	Pharmacy		14,690		4,287		5,345	15
16	Medical Records & Library		31,039		4,555		18,202	16
17	Social Service						3,529	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	80,324	94,828	41,355	79,844	278,796	122,871	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	73,042	104,109	10,307	29,473		40,351	50
53	Anesthesiology							53
54	Radiology-Diagnostic	129,411	50,050	14,108	19,559		39,199	54
57	CT Scan	203,152	8,296		4,555		4,926	57
58	MRI	48,258			2,679		6,498	58
60	Laboratory	312,713	105,993		15,540		49,225	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	62,330	57,844		11,789		26,377	65
66	Physical Therapy	56,768	97,179	2,877	8,306			66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	21,370			2,947			69
71	Medical Supplies Charged to Patients	38,301	16,591				2,201	71
72	Impl. Dev. Charged to Patients	7,182						72
73	Drugs Charged to Patients	64,683						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	28,516	38,522		19,291		38,884	88
90	Clinic	13,492	10,093				10,376	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	94,001	56,617	16,207	22,506		59,287	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,233,543	793,451	93,111	235,781	278,796	440,162	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		17,974		4,287		6,813	190
192	Physicians' Private Offices		4,649		10,449		4,332	192
192.01	TEMPORAILY IDLE SPACE		233,536					192.01
192.02	STH FAM HLTH CRT		63,927				28,124	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,233,543	1,113,537	93,111	250,517	278,796	479,431	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13	14.01	14.02	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							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	206,499						13
14	Central Services & Supply							14
14.01	PURCHASING		198,402					14.01
14.02	CENTRAL SERVICES & SUPPLY		202	5,561				14.02
15	Pharmacy		1,061		1,372,863			15
16	Medical Records & Library		429			488,309		16
17	Social Service						91,120	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	97,416	9,663			108,992	91,120	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	31,843	24,692	1		45,150		50
53	Anesthesiology							53
54	Radiology-Diagnostic		14,440			2,876		54
57	CT Scan		4,963					57
58	MRI		1,291					58
60	Laboratory		117,537			165,932		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		3,890			26,170		65
66	Physical Therapy		1,538	2		34,797		66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		549			15,242		69
71	Medical Supplies Charged to Patients			3,543				71
72	Impl. Dev. Charged to Patients			1,645				72
73	Drugs Charged to Patients				1,372,863			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	30,760	4,048			20,706		88
90	Clinic		1,344	11				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	46,480	8,922	5		68,444		91
92	Observation Beds (Non-Distinct Part)							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)	206,499	194,569	5,207	1,372,863	488,309	91,120	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		760	354				190
192	Physicians' Private Offices		202					192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		2,871					192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	206,499	198,402	5,561	1,372,863	488,309	91,120	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - GENERAL SERVICE COSTS **WORKSHEET B PART I**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							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 Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,932,056		3,932,056				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,857,855		1,857,855				50
53	Anesthesiology							53
54	Radiology-Diagnostic	1,710,519		1,710,519				54
57	CT Scan	515,102		515,102				57
58	MRI	642,111		642,111				58
60	Laboratory	2,970,863		2,970,863				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	842,556		842,556				65
66	Physical Therapy	1,179,599		1,179,599				66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	128,251		128,251				69
71	Medical Supplies Charged to Patients	608,610		608,610				71
72	Impl. Dev. Charged to Patients	244,683		244,683				72
73	Drugs Charged to Patients	1,437,546		1,437,546				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	1,217,011		1,217,011				88
90	Clinic	310,981		310,981				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	2,681,078		2,681,078				91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	20,278,821		20,278,821				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	180,114		180,114				190
192	Physicians' Private Offices	108,413		108,413				192
192.01	TEMPORAILY IDLE SPACE	450,011		450,011				192.01
192.02	STH FAM HLTH CRT	1,519,671		1,519,671				192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	22,537,030		22,537,030				202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & ACCOUNTING	
		0	1	2	2A	4	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		8,178	1,311	9,489	9,489		4
5.01	ADMINISTRATIVE & ACCOUNTING		338,941	16,955	355,896	666	356,562	5.01
5.02	BUSINESS SERVICES		91,267	188,283	279,550	621	19,517	5.02
6	Maintenance & Repairs							6
7	Operation of Plant		178,939	23,286	202,225	254	17,618	7
8	Laundry & Linen Service		12,761		12,761	31	1,233	8
9	Housekeeping		11,122	28	11,150	105	3,633	9
10	Dietary		41,168	2,468	43,636	70	3,544	10
11	Cafeteria					203	7,585	11
12	Maintenance of Personnel							12
13	Nursing Administration		5,800	654	6,454	129	3,065	13
14	Central Services & Supply							14
14.01	PURCHASING		19,431	401	19,832	99	2,662	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy		12,326	379	12,705	47	21,319	15
16	Medical Records & Library		26,043	5,062	31,105	183	6,868	16
17	Social Service					59	1,386	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		79,565	64,473	144,038	1,952	46,294	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		87,352	207,913	295,265	655	23,715	50
53	Anesthesiology							53
54	Radiology-Diagnostic		41,994	166,003	207,997	592	22,797	54
57	CT Scan		6,960	3,026	9,986	82	4,576	57
58	MRI			390,373	390,373	101	9,230	58
60	Laboratory		88,933	104,484	193,417	625	34,870	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		48,534	18,035	66,569	329	10,350	65
66	Physical Therapy		81,537	4,631	86,168		15,476	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology			5,177	5,177	94	1,395	69
71	Medical Supplies Charged to Patients		13,921	355	14,276	16	8,670	71
72	Impl. Dev. Charged to Patients						3,732	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		32,322	5,641	37,963	631	16,396	88
90	Clinic		8,468	7,418	15,886	175	4,361	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency		47,504	35,803	83,307	982	36,526	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		1,283,066	1,252,159	2,535,225	8,701	326,818	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		15,081	4,493	19,574	51	2,372	190
192	Physicians' Private Offices		3,901	2,542	6,443	56	1,405	192
192.01	TEMPORAILY IDLE SPACE		195,948		195,948		3,425	192.01
192.02	STH FAM HLTH CRT		53,638	13,001	66,639	681	22,542	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,551,634	1,272,195	2,823,829	9,489	356,562	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		5.02	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES	299,688						5.02
6	Maintenance & Repairs							6
7	Operation of Plant		220,097					7
8	Laundry & Linen Service		3,006	17,031				8
9	Housekeeping		2,620	1,394	18,902			9
10	Dietary		9,698	116	384	57,448		10
11	Cafeteria						7,788	11
12	Maintenance of Personnel							12
13	Nursing Administration		1,366				95	13
14	Central Services & Supply							14
14.01	PURCHASING		4,577				114	14.01
14.02	CENTRAL SERVICES & SUPPLY				404			14.02
15	Pharmacy		2,904		323		87	15
16	Medical Records & Library		6,135		344		296	16
17	Social Service						57	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	19,516	18,743	7,566	6,024	57,448	1,995	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,746	20,578	1,885	2,224		655	50
53	Anesthesiology							53
54	Radiology-Diagnostic	31,442	9,893	2,580	1,476		637	54
57	CT Scan	49,358	1,640		344		80	57
58	MRI	11,725			202		106	58
60	Laboratory	75,963	20,950		1,173		800	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	15,144	11,433		890		428	65
66	Physical Therapy	13,792	19,208	526	627			66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	5,192			222			69
71	Medical Supplies Charged to Patients	9,306	3,279				36	71
72	Impl. Dev. Charged to Patients	1,745						72
73	Drugs Charged to Patients	15,715						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	6,928	7,614		1,456		632	88
90	Clinic	3,278	1,995				169	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	22,838	11,191	2,964	1,698		963	91
92	Observation Beds (Non-Distinct Part)							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)	299,688	156,830	17,031	17,791	57,448	7,150	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		3,553		323		111	190
192	Physicians' Private Offices		919		788		70	192
192.01	TEMPORAILY IDLE SPACE		46,159					192.01
192.02	STH FAM HLTH CRT		12,636				457	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	299,688	220,097	17,031	18,902	57,448	7,788	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		13	14.01	14.02	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							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	11,109						13
14	Central Services & Supply							14
14.01	PURCHASING		27,284					14.01
14.02	CENTRAL SERVICES & SUPPLY		28	432				14.02
15	Pharmacy		146		37,531			15
16	Medical Records & Library		59			44,990		16
17	Social Service						1,502	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,241	1,329			10,042	1,502	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	1,713	3,396			4,160		50
53	Anesthesiology							53
54	Radiology-Diagnostic		1,986			265		54
57	CT Scan		683					57
58	MRI		178					58
60	Laboratory		16,161			15,288		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		535			2,411		65
66	Physical Therapy		211			3,206		66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		76			1,404		69
71	Medical Supplies Charged to Patients			276				71
72	Impl. Dev. Charged to Patients			128				72
73	Drugs Charged to Patients				37,531			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	1,655	557			1,908		88
90	Clinic		185	1				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	2,500	1,227			6,306		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	11,109	26,757	405	37,531	44,990	1,502	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		104	27				190
192	Physicians' Private Offices		28					192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		395					192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	11,109	27,284	432	37,531	44,990	1,502	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF CAPITAL-RELATED COSTS **WORKSHEET B PART II**

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		24	25	26				
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							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 Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	321,690		321,690				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	371,992		371,992				50
53	Anesthesiology							53
54	Radiology-Diagnostic	279,665		279,665				54
57	CT Scan	66,749		66,749				57
58	MRI	411,915		411,915				58
60	Laboratory	359,247		359,247				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	108,089		108,089				65
66	Physical Therapy	139,214		139,214				66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	13,560		13,560				69
71	Medical Supplies Charged to Patients	35,859		35,859				71
72	Impl. Dev. Charged to Patients	5,605		5,605				72
73	Drugs Charged to Patients	53,246		53,246				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	75,740		75,740				88
90	Clinic	26,050		26,050				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	170,502		170,502				91
92	Observation Beds (Non-Distinct Part)							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)	2,439,123		2,439,123				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	26,115		26,115				190
192	Physicians' Private Offices	9,709		9,709				192
192.01	TEMPORAILY IDLE SPACE	245,532		245,532				192.01
192.02	STH FAM HLTH CRT	103,350		103,350				192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,823,829		2,823,829				202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINISTRATIVE & ACCOUNTING ACCUM COST	BUSINESS SERVICES GROSS CHARGES	
		1	2	4	5A.01	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	107,004						1
2	Cap Rel Costs-Mvble Equip		1,482,156					2
4	Employee Benefits Department	564	1,527	9,060,364				4
5.01	ADMINISTRATIVE & ACCOUNTING	23,374	19,753	636,083	-2,137,005	20,400,025		5.01
5.02	BUSINESS SERVICES	6,294	219,357	593,560		1,116,576	51,151,632	5.02
6	Maintenance & Repairs							6
7	Operation of Plant	12,340	27,129	242,134		1,007,949		7
8	Laundry & Linen Service	880		29,132		70,516		8
9	Housekeeping	767	33	99,919		207,866		9
10	Dietary	2,839	2,875	67,085		202,763		10
11	Cafeteria			193,918		433,970		11
12	Maintenance of Personnel							12
13	Nursing Administration	400	762	123,140		175,348		13
14	Central Services & Supply							14
14.01	PURCHASING	1,340	467	94,410		152,271		14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy	850	441	45,126		1,219,709		15
16	Medical Records & Library	1,796	5,897	174,439		392,923		16
17	Social Service			55,899		79,285		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,487	75,114	1,860,415		2,649,317	3,330,873	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,024	242,226	625,733		1,356,760	3,028,918	50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,896	193,400	565,847		1,304,249	5,366,414	54
57	CT Scan	480	3,525	78,763		261,787	8,424,300	57
58	MRI		454,800	96,906		528,067	2,001,148	58
60	Laboratory	6,133	121,728	597,362		1,994,943	12,966,698	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,347	21,012	314,102		592,128	2,584,718	65
66	Physical Therapy	5,623	5,395			885,384	2,354,044	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		6,031	89,633		79,785	886,176	69
71	Medical Supplies Charged to Patients	960	414	15,395		496,014	1,588,258	71
72	Impl. Dev. Charged to Patients					213,492	297,804	72
73	Drugs Charged to Patients						2,682,270	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	2,229	6,572	602,435		938,022	1,182,494	88
90	Clinic	584	8,642	167,603		249,526	559,501	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	3,276	41,712	938,160		2,089,702	3,898,016	91
92	Observation Beds (Non-Distinct Part)							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)	88,483	1,458,812	8,307,199	-2,137,005	18,698,352	51,151,632	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,040	5,235	49,006		135,710		190
192	Physicians' Private Offices	269	2,962	53,621		80,363		192
192.01	TEMPORAILY IDLE SPACE	13,513				195,948		192.01
192.02	STH FAM HLTH CRT	3,699	15,147	650,538		1,289,652		192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,551,634	1,272,195	2,283,585		2,137,005	1,233,543	202
203	Unit Cost Multiplier (Wkst. B, Part I)	14.500710	0.858341	0.252041		0.104755	0.024115	203
204	Cost to be allocated (Per Wkst. B, Part II)			9,489		356,562	299,688	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.001047		0.017479	0.005859	205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	Maintenance & Repairs	76,772						6
7	Operation of Plant	12,340	64,432					7
8	Laundry & Linen Service	880	880	19,160				8
9	Housekeeping	767	767	1,568	935			9
10	Dietary	2,839	2,839	131	19	6,527		10
11	Cafeteria						13,723	11
12	Maintenance of Personnel							12
13	Nursing Administration	400	400				168	13
14	Central Services & Supply							14
14.01	PURCHASING	1,340	1,340				201	14.01
14.02	CENTRAL SERVICES & SUPPLY				20			14.02
15	Pharmacy	850	850		16		153	15
16	Medical Records & Library	1,796	1,796		17		521	16
17	Social Service						101	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,487	5,487	8,510	298	6,527	3,517	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,024	6,024	2,121	110		1,155	50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,896	2,896	2,903	73		1,122	54
57	CT Scan	480	480		17		141	57
58	MRI				10		186	58
60	Laboratory	6,133	6,133		58		1,409	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,347	3,347		44		755	65
66	Physical Therapy	5,623	5,623	592	31			66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology				11			69
71	Medical Supplies Charged to Patients	960	960				63	71
72	Impl. Dev. Charged to Patients							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	2,229	2,229		72		1,113	88
90	Clinic	584	584				297	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	3,276	3,276	3,335	84		1,697	91
92	Observation Beds (Non-Distinct Part)							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)	58,251	45,911	19,160	880	6,527	12,599	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	1,040	1,040		16		195	190
192	Physicians' Private Offices	269	269		39		124	192
192.01	TEMPORAILY IDLE SPACE	13,513	13,513					192.01
192.02	STH FAM HLTH CRT	3,699	3,699				805	192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)		1,113,537	93,111	250,517	278,796	479,431	202
203	Unit Cost Multiplier (Wkst. B, Part I)		17.282360	4.859656	267.932620	42.714264	34.936311	203
204	Cost to be allocated (Per Wkst. B, Part II)		220,097	17,031	18,902	57,448	7,788	204
205	Unit Cost Multiplier (Wkst. B, Part II)		3.415958	0.888883	20.216043	8.801593	0.567514	205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION DIRECT NRSING HRS	PURCHASING COSTED REQUIS.	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	
		13	14.01	14.02	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							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	155,216						13
14	Central Services & Supply							14
14.01	PURCHASING		1,377,365					14.01
14.02	CENTRAL SERVICES & SUPPLY		1,405	721,507				14.02
15	Pharmacy		7,369		1,000			15
16	Medical Records & Library		2,981			1,698		16
17	Social Service						2,594	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	73,223	67,086			379	2,594	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	23,935	171,421	102		157		50
53	Anesthesiology							53
54	Radiology-Diagnostic		100,248			10		54
57	CT Scan		34,457					57
58	MRI		8,962					58
60	Laboratory		815,964			577		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		27,003			91		65
66	Physical Therapy		10,675	201		121		66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology		3,814			53		69
71	Medical Supplies Charged to Patients			459,729				71
72	Impl. Dev. Charged to Patients			213,492				72
73	Drugs Charged to Patients				1,000			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	23,121	28,105	27		72		88
90	Clinic		9,328	1,444				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	34,937	61,942	631		238		91
92	Observation Beds (Non-Distinct Part)							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)	155,216	1,350,760	675,626	1,000	1,698	2,594	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,275	45,881				190
192	Physicians' Private Offices		1,401					192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		19,929					192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	206,499	198,402	5,561	1,372,863	488,309	91,120	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.330398	0.144045	0.007707	1,372.863000	287.578916	35.127217	203
204	Cost to be allocated (Per Wkst. B, Part II)	11,109	27,284	432	37,531	44,990	1,502	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.071571	0.019809	0.000599	37.531000	26.495878	0.579029	205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - STATISTICAL BASIS **WORKSHEET B-1**

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							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 Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							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							88
90	Clinic							90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							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)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT							192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

POST STEPDOWN ADJUSTMENTS **WORKSHEET B-2**

		WORKSHEET			
	DESCRIPTION	PART	LINE NO.	AMOUNT	
	1	2	3	4	

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis-allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	3,932,056		3,932,056		3,932,056	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,857,855		1,857,855		1,857,855	50
53	Anesthesiology						53
54	Radiology-Diagnostic	1,710,519		1,710,519		1,710,519	54
57	CT Scan	515,102		515,102		515,102	57
58	MRI	642,111		642,111		642,111	58
60	Laboratory	2,970,863		2,970,863		2,970,863	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	842,556		842,556		842,556	65
66	Physical Therapy	1,179,599		1,179,599		1,179,599	66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology	128,251		128,251		128,251	69
71	Medical Supplies Charged to Patients	608,610		608,610		608,610	71
72	Impl. Dev. Charged to Patients	244,683		244,683		244,683	72
73	Drugs Charged to Patients	1,437,546		1,437,546		1,437,546	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	1,217,011		1,217,011		1,217,011	88
90	Clinic	310,981		310,981		310,981	90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	2,681,078		2,681,078		2,681,078	91
92	Observation Beds (Non-Distinct Part)	465,731		465,731		465,731	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
200	Subtotal (sum of lines 30 thru 199)	20,744,552		20,744,552		20,744,552	200
201	Less Observation Beds	465,731		465,731		465,731	201
202	Total (line 200 minus line 201)	20,278,821		20,278,821		20,278,821	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	2,943,803		2,943,803				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	455,930	2,572,988	3,028,918	0.613372	0.613372	0.613372	50
53	Anesthesiology							53
54	Radiology-Diagnostic	373,135	4,993,279	5,366,414	0.318745	0.318745	0.318745	54
57	CT Scan	507,347	7,916,953	8,424,300	0.061145	0.061145	0.061145	57
58	MRI	74,336	1,926,812	2,001,148	0.320871	0.320871	0.320871	58
60	Laboratory	1,034,183	11,932,515	12,966,698	0.229115	0.229115	0.229115	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,100,685	1,484,033	2,584,718	0.325976	0.325976	0.325976	65
66	Physical Therapy	371,343	1,982,701	2,354,044	0.501095	0.501095	0.501095	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	25,624	860,552	886,176	0.144724	0.144724	0.144724	69
71	Medical Supplies Charged to Patients	419,546	1,168,712	1,588,258	0.383193	0.383193	0.383193	71
72	Impl. Dev. Charged to Patients	149,852	147,952	297,804	0.821624	0.821624	0.821624	72
73	Drugs Charged to Patients	687,570	1,994,700	2,682,270	0.535944	0.535944	0.535944	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		1,182,494	1,182,494				88
90	Clinic		559,501	559,501	0.555818	0.555818	0.555818	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency		3,898,016	3,898,016	0.687806	0.687806	0.687806	91
92	Observation Beds (Non-Distinct Part)		387,070	387,070	1.203222	1.203222	1.203222	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
200	Subtotal (sum of lines 30 thru 199)	8,143,354	43,008,278	51,151,632				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	8,143,354	43,008,278	51,151,632				202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1345** **WORKSHEET D PART V**

Check Applicable Boxes: **[ ] Title V - O/P** **[XX] Title XVIII, Part B** **[ ] Title XIX - O/P** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] Swing Bed SNF** **[ ] Swing Bed NF** **[ ] ICF/MR**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.613372		1,574,950			966,030		50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.318745		1,960,957			625,045		54
57	CT Scan	0.061145		3,172,532			193,984		57
58	MRI	0.320871		699,396			224,416		58
60	Laboratory	0.229115		3,635,897			833,039		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.325976		708,395			230,920		65
66	Physical Therapy	0.501095		578,102			289,684		66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	0.144724		441,531			63,900		69
71	Medical Supplies Charged to Patients	0.383193		463,669			177,675		71
72	Impl. Dev. Charged to Patients	0.821624		107,719			88,505		72
73	Drugs Charged to Patients	0.535944		946,121			507,068		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								88
90	Clinic	0.555818		199,058			110,640		90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.687806		1,450,147			997,420		91
92	Observation Beds (Non-Distinct Part)	1.203222		214,401			257,972		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			16,152,875			5,566,298		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			16,152,875			5,566,298		202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-Z345** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[ ] Hospital** **[ ] SUB (Other)** **[XX] Swing Bed SNF**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/MR**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.613372							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.318745							54
57	CT Scan	0.061145							57
58	MRI	0.320871							58
60	Laboratory	0.229115							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.325976							65
66	Physical Therapy	0.501095							66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	0.144724							69
71	Medical Supplies Charged to Patients	0.383193							71
72	Impl. Dev. Charged to Patients	0.821624							72
73	Drugs Charged to Patients	0.535944							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								88
90	Clinic	0.555818							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.687806							91
92	Observation Beds (Non-Distinct Part)	1.203222							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

Check Applicable Boxes:
[ ] Title V
[ ] Title XVIII, Part A
[XX] Title XIX

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust-ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	321,690	56,103	265,587	2,349	113.06	39	4,409	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	321,690		265,587	2,349		39	4,409	200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS **COMPONENT CCN: 14-1345** **WORKSHEET D PART II**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII, Part A** **[XX] Title XIX** **[XX] Hospital** **[ ] IPF** **[ ] IRF** **[ ] SUB (Other)**

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	371,992	3,028,918	0.122813			50
53	Anesthesiology						53
54	Radiology-Diagnostic	279,665	5,366,414	0.052114			54
57	CT Scan	66,749	8,424,300	0.007923			57
58	MRI	411,915	2,001,148	0.205839			58
60	Laboratory	359,247	12,966,698	0.027705			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	108,089	2,584,718	0.041818			65
66	Physical Therapy	139,214	2,354,044	0.059138			66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology	13,560	886,176	0.015302			69
71	Medical Supplies Charged to Patients	35,859	1,588,258	0.022578			71
72	Impl. Dev. Charged to Patients	5,605	297,804	0.018821			72
73	Drugs Charged to Patients	53,246	2,682,270	0.019851			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	75,740	1,182,494	0.064051			88
90	Clinic	26,050	559,501	0.046559			90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	170,502	3,898,016	0.043741			91
92	Observation Beds (Non-Distinct Part)	46,151	387,070	0.119232			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,163,584	48,207,829				200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust-ment Amount (see instruct-ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics General Routine Care)						30
31	Intensive Care Unit						31
32	Coronary Care Unit						32
33	Burn Intensive Care Unit						33
34	Surgical Intensive Care Unit						34
35	Other Special Care (specify)						35
40	Subprovider - IPF						40
41	Subprovider - IRF						41
42	Subprovider I						42
43	Nursery						43
44	Skilled Nursing Facility						44
45	Nursing Facility						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check Applicable Boxes:
[ ] Title V [ ] PPS
[ ] Title XVIII, Part A [ ] TEFRA
[XX] Title XIX [XX] Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,349		39		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	2,349		39		200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1345** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] Other

		Non Physician Anesth-etist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							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							88
90	Clinic							90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | **COMPONENT CCN: 14-1345** | **WORKSHEET D PART IV**

Check Applicable Boxes: [ ] Title V [XX] Title XVIII, Part A [XX] Title XIX | [XX] Hospital [ ] IPF [ ] IRF | [ ] SUB (Other) [ ] SNF [ ] NF | [ ] ICF/MR | [ ] PPS [ ] TEFRA [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	3,028,918							50
53	Anesthesiology								53
54	Radiology-Diagnostic	5,366,414							54
57	CT Scan	8,424,300							57
58	MRI	2,001,148							58
60	Laboratory	12,966,698							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,584,718							65
66	Physical Therapy	2,354,044							66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	886,176							69
71	Medical Supplies Charged to Patients	1,588,258							71
72	Impl. Dev. Charged to Patients	297,804							72
73	Drugs Charged to Patients	2,682,270							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	1,182,494							88
90	Clinic	559,501							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	3,898,016							91
92	Observation Beds (Non-Distinct Part)	387,070							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	48,207,829							200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS **COMPONENT CCN: 14-1345** **WORKSHEET D PART V**

Check Applicable Boxes:
[ ] Title V - O/P **[XX] Hospital** **[ ] SUB (Other)** **[ ] Swing Bed SNF**
[ ] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[XX] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/MR**

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.613372							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.318745							54
57	CT Scan	0.061145							57
58	MRI	0.320871							58
60	Laboratory	0.229115							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.325976							65
66	Physical Therapy	0.501095							66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	0.144724							69
71	Medical Supplies Charged to Patients	0.383193							71
72	Impl. Dev. Charged to Patients	0.821624							72
73	Drugs Charged to Patients	0.535944							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								88
90	Clinic	0.555818							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.687806							91
92	Observation Beds (Non-Distinct Part)	1.203222							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1345** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[ ] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,931	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,349	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	2,012	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	366	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)	122	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	71	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	23	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,432	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)	366	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)	122	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 XIX only)		15
16	Nursery days (title V or 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)	3,932,056	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)	8,565	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,774	25
26	Total swing-bed cost (see instructions)	685,750	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,246,306	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	3,246,306	37

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1345** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,381.99	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,979,010	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)					1,979,010	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,110,877	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					3,089,887	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 (sum of lines 50 and 51)						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 (line 56 minus line 53)						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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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)					505,808	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					168,603	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					674,411	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

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/MR [ ] PPS
[XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[ ] Title XIX - I/P [ ] IRF [ ] NF [XX] Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					337	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,381.99	88
89	Observation bed cost (line 87 x line 88) (see instructions)					465,731	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	321,690	3,246,306	0.099094	465,731	46,151	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1345** **WORKSHEET D-1 PART I**

Check Applicable Boxes:	**[ ] Title V - I/P**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] ICF/MR**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**		**[ ] TEFRA**
	[XX] Title XIX - I/P	**[ ] IRF**	**[ ] NF**		**[XX] Other**

PART I - ALL PROVIDER COMPONENTS

	INPATIENT DAYS		
1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,931	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,349	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	2,012	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	366	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)	122	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	71	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	23	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	39	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 XIX only)		15
16	Nursery days (title V or 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)	3,932,056	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)	8,565	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,774	25
26	Total swing-bed cost (see instructions)	685,750	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,246,306	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		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)		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 minus line 36)	3,246,306	37

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COMPUTATION OF INPATIENT OPERATING COST **COMPONENT CCN: 14-1345** **WORKSHEET D-1 PART II**

Check Applicable Boxes: [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] TEFRA
[XX] Title XIX - I/P [ ] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS					1	
38	Adjusted general inpatient routine service cost per diem (see instructions)					1,381.99	38
39	Program general inpatient routine service cost (line 9 x line 38)					53,898	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)					53,898	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					53,898	49
	PASS THROUGH COST ADJUSTMENTS						
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					4,409	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 (sum of lines 50 and 51)					4,409	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 (line 56 minus line 53)						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 (line 54 x 60), or 1% of the target amount (line 56), otherwise etner 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)					337	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1345** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[XX] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[ ] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,493,507		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.613372	249,512	153,044	50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.318745	237,565	75,723	54
57	CT Scan	0.061145	332,661	20,341	57
58	MRI	0.320871	54,493	17,485	58
60	Laboratory	0.229115	678,780	155,519	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.325976	733,239	239,018	65
66	Physical Therapy	0.501095	59,991	30,061	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.144724	17,668	2,557	69
71	Medical Supplies Charged to Patients	0.383193	236,408	90,590	71
72	Impl. Dev. Charged to Patients	0.821624	115,462	94,866	72
73	Drugs Charged to Patients	0.535944	432,270	231,673	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				88
90	Clinic	0.555818			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.687806			91
92	Observation Beds (Non-Distinct Part)	1.203222			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,148,049	1,110,877	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,148,049		202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-Z345** **WORKSHEET D-3**

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[ ] Title XIX**
[ ] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[XX] Swing Bed SNF **[ ] Swing Bed NF** **[ ] ICF/MR**
[ ] PPS **[ ] TEFRA** **[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.613372			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.318745	8,339	2,658	54
57	CT Scan	0.061145	3,583	219	57
58	MRI	0.320871			58
60	Laboratory	0.229115	50,930	11,669	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.325976	42,959	14,004	65
66	Physical Therapy	0.501095	257,160	128,862	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.144724	904	131	69
71	Medical Supplies Charged to Patients	0.383193	78,336	30,018	71
72	Impl. Dev. Charged to Patients	0.821624			72
73	Drugs Charged to Patients	0.535944	63,748	34,165	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				88
90	Clinic	0.555818			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.687806			91
92	Observation Beds (Non-Distinct Part)	1.203222			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		505,959	221,726	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		505,959		202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **COMPONENT CCN: 14-1345** **WORKSHEET D-3**

Check Applicable Boxes:	**[ ] Title V**	**[XX] Hospital**	**[ ] SUB (Other)**	**[ ] Swing Bed SNF**	**[ ] PPS**
	[ ] Title XVIII, Part A	**[ ] IPF**	**[ ] SNF**	**[ ] Swing Bed NF**	**[ ] TEFRA**
	[XX] Title XIX	**[ ] IRF**	**[ ] NF**	**[ ] ICF/MR**	**[XX] Other**

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges 1	Inpatient Program Charges 2	Inpatient Program Costs (col. 1 x col. 2) 3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.613372			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.318745			54
57	CT Scan	0.061145			57
58	MRI	0.320871			58
60	Laboratory	0.229115			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.325976			65
66	Physical Therapy	0.501095			66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.144724			69
71	Medical Supplies Charged to Patients	0.383193			71
72	Impl. Dev. Charged to Patients	0.821624			72
73	Drugs Charged to Patients	0.535944			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				88
90	Clinic	0.555818			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.687806			91
92	Observation Beds (Non-Distinct Part)	1.203222			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1345** **WORKSHEET E PART B**

Check applicable box: [XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)	5,566,298			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,566,298			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	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)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over ressonable cost (complete only if line 18 exceeds line 11 (see instructions)				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions)				20
21	Lesser of cost or charges (line 11 minus line 20) (for CAH, see instructions)	5,621,961			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	49,777			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,610,441			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,961,743			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	2,961,743			30
31	Primary payer payments	664			31
32	Subtotal (line 30 minus line 31)	2,961,079			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	369,615			34
35	Adjusted reimbursable bad debts (see instructions)	280,907			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	309,882			36
37	Subtotal (see instructions)	3,241,986			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,241,986			40
40.01	Sequestration adjustment (see instructions)	64,840			40.01
41	Interim payments	3,450,803			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-273,657			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (sse instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-1345** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[XX] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [ ] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				3,135,793		4,046,012	1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01	03/31/2015	58,380			3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	11/30/2014	129,679	11/30/2014	456,425	3.51
		Provider	.52			03/31/2015	138,784	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		-71,299		-595,209	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				3,064,494		3,450,803	4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01					6.01
	based on the cost report (1)		.02		-260,117		-208,817	6.02
7	Total Medicare program liability (see instructions)				2,804,377		3,241,986	7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED **COMPONENT CCN: 14-Z345** **WORKSHEET E-1 PART I**

Check Applicable Boxes: **[ ] Hospital [ ] IPF [ ] IRF [ ] SUB (Other) [ ] SNF [XX] Swing Bed SNF**

				INPATIENT PART A		PART B		
				mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
	DESCRIPTION			1	2	3	4	
1	Total interim payments paid to provider				744,323			1
2	Interim payments payable on individual bills, eitehr submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero							2
3	List separately each retroactive lump sum adjustment		.01					3.01
	amount based on subsequent revision of the interim		.02					3.02
	rate for the cost reporting period. Also show date of	Program	.03					3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04					3.04
		Provider	.05					3.05
			.06					3.06
			.07					3.07
			.08					3.08
			.09					3.09
			.10					3.10
			.50					3.50
			.51	11/30/2014	30,411			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		-30,411			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				713,912			4
	TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03					5.03
		to	.04					5.04
		Provider	.05					5.05
			.06					5.06
			.07					5.07
			.08					5.08
			.09					5.09
			.10					5.10
			.50					5.50
			.51					5.51
		Provider	.52					5.52
		to	.53					5.53
		Program	.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	Determined net settlement amount (balance due)		.01		179,568			6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				893,480			7
8	Name of Contractor			Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: **[XX] Hospital** **[ ] CAH**

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 (Wkst. S-3, Pt. I, col. 15, line 14)	556	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,432	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	71	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	2,012	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	51,151,632	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	255,114	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	1	7
8	Calculation of the HIT incentive payment (see instructions)	1	8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	Initial/interim HIT payment(s)		30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	1	32

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS **COMPONENT CCN: 14-Z345** **WORKSHEET E-2**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX** **[XX] Swing Bed - SNF** **[ ] Swing Bed - NF**

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	681,155		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, Pt. V, cols. 5 and 7, line 202 for Part B) (For CAH, see instructions)	223,943		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	488		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 through 3 plus lines 6 and 7)	905,098		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	905,098		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	905,098		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,618		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)	893,480		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			17
17.01	Adjusted reimbursable bad debts (see instructions)			17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19	Total (see instructions)	893,480		19
19.01	Sequestration adjustment (see instructions)	17,870		19.01
20	Interim payments	713,912		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	161,698		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, §115.2			23

CALCULATION OF REIMBURSEMENT SETTLEMENT **WORKSHEET E-3**
PART V

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

1	Inpatient services	3,089,887	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	3,089,887	4
5	Primary payer payments	284	5
6	Total cost (line 4 less line 5) (see instructions)	3,120,502	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)	0.000000	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 instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	3,120,502	19
20	Deductibles (exclude professional component)	355,178	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,765,324	22
23	Coinsurance	2,432	23
24	Subtotal (line 22 minus line 23)	2,762,892	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	54,586	25
26	Adjusted reimbursable bad debts (see instructions)	41,485	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	47,733	27
28	Subtotal (sum of lines 24 and 26)	2,804,377	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,804,377	30
30.01	Sequestration adjustment (see instructions)	56,088	30.01
31	Interim payments	3,064,494	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-316,205	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT **COMPONENT CCN: 14-1345** **WORKSHEET E-3 PART VII**

Check Applicable Boxes: **[ ] Title V** **[XX] Title XIX** **[XX] Hospital** **[ ] SUB (Other)** **[ ] SNF** **[ ] NF** **[ ] ICF/MR** **[ ] PPS** **[ ] TEFRA** **[XX] Other**

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

		INPATIENT TITLE V OR TITLE XIX	OUTPATIENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	53,898		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	53,898		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	53,898		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 cahrge 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)	1.000000	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 physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	53,898		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	Titles V or XIX (sum of lines 21 and 27)	53,898		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)	53,898		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)	53,898		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	53,898		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)	53,898		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	53,898		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

BALANCE SHEET **WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT ASSETS					
1	Cash on hand and in banks	6,397,889				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	6,391,908				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-2,000,000				6
7	Inventory	393,914				7
8	Prepaid expenses	472,680				8
9	Other current assets	556,802				9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	12,213,193				11
	FIXED ASSETS					
12	Land	134,756				12
13	Land improvements	1,160,946				13
14	Accumulated depreciation	-757,142				14
15	Buildings	36,896,732				15
16	Accumulated depreciation	-9,423,817				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	2,101,871				19
20	Accumulated depreciation	-1,169,341				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	9,945,037				23
24	Accumulated depreciation	-8,179,379				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	30,709,663				30
	OTHER ASSETS					
31	Investments	2,150,213				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	2,194,210				34
35	Total other assets (sum of lines 31-34)	4,344,423				35
36	Total assets (sum of lines 11, 30 and 35)	47,267,279				36

	Liabilities and Fund Balances	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	2,500,247				37
38	Salaries, wages and fees payable	1,179,760				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	548,178				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	1,144,222				43
44	Other current liabilities	325,813				44
45	Total current liabilities (sum of lines 37 thru 44)	5,698,220				45
	LONG TERM LIABILITIES					
46	Mortgage payable	14,360,800				46
47	Notes payable	2,450,656				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	16,811,456				50
51	Total liabilities (sum of lines 45 and 50)	22,509,676				51
	CAPITAL ACCOUNTS					
52	General fund balance	24,757,603				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					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 thru 58)	24,757,603				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	47,267,279				60

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

STATEMENT OF CHANGES IN FUND BALANCES **WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		24,101,777			1
2	Net income (loss) (from Worksheet G-3, line 29)		655,826			2
3	Total (sum of line 1 and line 2)		24,757,603			3
4	Additions (credit adjustments) (specify)					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)		24,757,603			11
12	Deductions (debit adjustments) (specify)					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)		24,757,603			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					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)					11
12	Deductions (debit adjustments) (specify)					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)					19

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

		INPATIENT	OUTPATIENT	TOTAL	
	REVENUE CENTER	1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	2,545,292		2,545,292	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	398,511		398,511	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)	2,943,803		2,943,803	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	2,943,803		2,943,803	17
18	Ancillary services	5,404,443	36,448,360	41,852,803	18
19	Outpatient services		7,287,088	7,287,088	19
20	Rural Health Clinic (RHC)		1,182,494	1,182,494	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		2,732,115	2,732,115	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	8,348,246	47,650,057	55,998,303	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		25,698,214	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 Worksheet G-3, line 4)		25,698,214	43

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

STATEMENT OF REVENUES AND EXPENSES **WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	55,998,303	1
2	Less contractual allowances and discounts on patients' accounts	30,784,189	2
3	Net patient revenues (line 1 minus line 2)	25,214,114	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	25,698,214	4
5	Net income from service to patients (line 3 minus line 4)	-484,100	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	4,221	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	580	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	148,114	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr 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, flowers, coffee shops and canteen	65,708	20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (PROPERTY TAX REVENUE)	252,603	24
24.01	Other (OTHER OPERATING INCOME (EXPENSE))	50,886	24.01
24.02	Other (NONCAPITAL GRANTS AND CONTRIBUTIONS)	308,879	24.02
24.03	Other (CAPITAL GRANTS AND CONTRIBUTIONS)	12,000	24.03
24.04	Other (EHR MEDICAID REVENUE)	86,794	24.04
24.05	Other (340(B) REVENUE)	219,774	24.05
25	Total other income (sum of lines 6-24)	1,149,559	25
26	Total (line 5 plus line 25)	665,459	26
27	Other expenses (LOSS ON DISPOSITION OF EQUIPMENT)	9,633	27
28	Total other expenses (sum of line 27 and subscripts)	9,633	28
29	Net income (or loss) for the period (line 26 minus line 28)	655,826	29

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7429** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see ins-tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General						5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech Pathology						9
10	Medical Social Services						10
11	Home Health Aide						11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)						24

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7429** **WORKSHEET H**

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTERS						
1	Capital Related-Bldgs and Fixtures						1
2	Capital Related-Movable Equipment						2
3	Plant Operation & Maintenance						3
4	Transportation (see instructions)						4
5	Administrative and General						5
	HHA REIMBURSABLE SERVICES						
6	Skilled Nursing Care						6
7	Physical Therapy						7
8	Occupational Therapy						8
9	Speech Pathology						9
10	Medical Social Services						10
11	Home Health Aide						11
12	Supplies (see instructions)						12
13	Drugs						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	Home Dialysis Aide Services						15
16	Respiratory Therapy						16
17	Private Duty Nursing						17
18	Clinic						18
19	Health Promotion Activities						19
20	Day Care Program						20
21	Home Delivered Meals Program						21
22	Homemaker Service						22
23	All Others						23
23.50	Telemedicine						23.50
24	Total (sum of lines 1-23)						24

Column 6, line 24 should agree with Worksheet A, column 3, line 101, or subscript as applicable.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7429** **WORKSHEET H-1 PART I**

			CAPITAL RELATED COSTS			
		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General					5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care					6
7	Physical Therapy					7
8	Occupational Therapy					8
9	Speech Pathology					9
10	Medical Social Services					10
11	Home Health Aide					11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)					24

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS **HHA CCN: 14-7429** **WORKSHEET H-1 PART I**

		TRANSPORT-ATION	SUBTOTAL (cols. 0-4)	ADMINI-STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTERS					
1	Capital Related-Bldgs. and Fixtures					1
2	Capital Related-Movable Equipment					2
3	Plant Operation & Maintenance					3
4	Transportation (see instructions)					4
5	Administrative and General					5
	HHA REIMBURSABLE SERVICES					
6	Skilled Nursing Care					6
7	Physical Therapy					7
8	Occupational Therapy					8
9	Speech Pathology					9
10	Medical Social Services					10
11	Home Health Aide					11
12	Supplies (see instructions)					12
13	Drugs					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	Home Dialysis Aide Services					15
16	Respiratory Therapy					16
17	Private Duty Nursing					17
18	Clinic					18
19	Health Promotion Activities					19
20	Day Care Program					20
21	Home Delivered Means Program					21
22	Homemaker Service					22
23	All Others					23
23.50	Telemedicine					23.50
24	Totals (sum of lines 1-23)					24

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

COST ALLOCATION - HHA STATISTICAL BASIS **HHA CCN: 14-7429** **WORKSHEET H-1 PART II**

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORT-ATION (Mileage)	RECONCIL-IATION	ADMINI-STRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General							5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech Pathology							9
10	Medical Social Services							10
11	Home Health Aide							11
12	Supplies (see instructions)							12
13	Drugs							13
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Means Program							21
22	Homemaker Service							22
23	All Others							23
23.50	Telemedicine							23.50
24	Totals (sum of lines 1-23)							24
25	Cost To Be Allocated (per Worksheet H-1, Part I)							25
26	Unit Cost Multiplier							26

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7429** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRATIVE & ACCOUNTING	
		0	1	2	4	4A	5.01	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)							20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7429** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	BUSINESS SERVICES	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.02	6	7	8	9	10	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)							20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7429** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PURCHASING	CENTRAL SERVICES & SUPPLY	
		11	12	13	14	14.01	14.02	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)							20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7429** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	
		15	16	17	19	20	21	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)							20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7429** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP-DOWN ADJS	SUBTOTAL (cols 23 +/- 24)	ALLOCATED HHA A&G (see PtII)	
		22	23	24	25	26	27	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)							20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS **HHA CCN: 14-7429** **WORKSHEET H-2 PART I**

	HHA COST CENTER (omit cents)	TOTAL HHA COSTS						
		28						
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
20	Totals (sum of lines 1-19)(2)							20
21	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7429** **WORKSHEET H-2 PART II**

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINISTRATIVE & ACCOUNTING ACCUM COST	BUSINESS SERVICES GROSS CHARGES	
		1	2	4	4A.01	5.01	5.02	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7429** **WORKSHEET H-2 PART II**

	HHA COST CENTER	MAIN-TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	
		6	7	8	9	10	11	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7429** **WORKSHEET H-2 PART II**

	HHA COST CENTER	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS-TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PURCHASING COSTED REQUIS.	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	
		12	13	14	14.01	14.02	15	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7429** **WORKSHEET H-2 PART II**

	HHA COST CENTER	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	
		16	17	19	20	21	22	
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS **HHA CCN: 14-7429** **WORKSHEET H-2 PART II**

	HHA COST CENTER	PARAMED EDUCATION ASSIGNED TIME						
		23						
1	Administrative and General							1
2	Skilled Nursing Care							2
3	Physical Therapy							3
4	Occupational Therapy							4
5	Speech Pathology							5
6	Medical Social Services							6
7	Home Health Aide							7
8	Supplies							8
9	Drugs							9
10	DME							10
11	Home Dialysis Aide Services							11
12	Respiratory Therapy							12
13	Private Duty Nursing							13
14	Clinic							14
15	Health Promotion Activities							15
16	Day Care Program							16
17	Home Delivered Meals Program							17
18	Homemaker Service							18
19	All Others							19
19.50	Telemedicine							19.50
20	Totals (sum of lines 1-19)							20
21	Total cost to be allocated							21
22	Unit Cost Multiplier							22
22	Unit Cost Multiplier							22

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7429** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation

	Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA COSTS (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	Skilled Nursing Care	2						1
2	Physical Therapy	3						2
3	Occupational Therapy	4						3
4	Speech Pathology	5						4
5	Medical Social Services	6						5
6	Home Health Aide	7						6
7	Total (sum of lines 1-6)							7

Limitation Cost Comoputation

			Program Visits			
				PART B		
	Patient Services	CBSA No.	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	
8	Skilled Nursing Care	16460				8
9	Physical Therapy	16460				9
10	Occupational Therapy	16460				10
11	Speech Pathology	16460				11
12	Medical Social Services	16460				12
13	Home Health Aide	16460				13
14	Total (sum of lines 8-13)					14

Supplies and Drugs Cost Computations

	Other Patient Services	From Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	Cost of Medical Supplies	8						15
16	Cost of Drugs	9						16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	66	0.501095			col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Medical Supplies Charged to Pat	71	0.383193			col. 2, line 15	4
5	Drugs Charged to Patients	73	0.535944			col. 2, line 16	5

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

APPORTIONMENT OF PATIENT SERVICE COSTS **HHA CCN: 14-7429** **WORKSHEET H-3 PARTS I & II**

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation		Program Visits			Cost of Services				
			Part B			Part B			
	Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	Skilled Nursing Care								1
2	Physical Therapy								2
3	Occupational Therapy								3
4	Speech Pathology								4
5	Medical Social Services								5
6	Home Health Aide								6
7	Total (sum of lines 1-6)								7

Supplies and Drugs Cost Computations		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Other Patient Services	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6	7	8	9	10	11	
15	Cost of Medical Supplies							15
16	Cost of Drugs							16

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

CALCULATION OF HHA REIMBURSEMRNT SETTLEMENT **HHA CCN: 14-7429** **WORKSHEET H-4**
PARTS I & II

Check applicable box: [ ] Title V [XX] Title XVIII [ ] Title XIX

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

			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	Description	1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)				4
5	Ratio of line 3 to line 4 (not to excced 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		Part A Services	Part B Services	
	Description	1	2	
10	Total reasonable cost (see instructions)			10
11	Total PPS Reimbursement - Full Episodes without Outliers			11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes			13
14	Total PPS Reimbursement - PEP Episodes			14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PSP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)			22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)			24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)			26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			30.50
31	Subtotal (see instructions)			31
31.01	Sequestration adjustment (see instructions)			31.01
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115-2			35

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI-NARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		0	2A	24	25	26		
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							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 Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							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							88
90	Clinic							90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							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)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT							192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS **COMPONENT CCN: 14-3413** **WORKSHEET M-1**

Check applicable box: [XX] RHC I [ ] FQHC

		COMPENS-ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS-IFICATIONS	RECLASS-IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST-MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	59,405	4,400	63,805	-30,833	32,972		32,972	1
2	Physician Assistant								2
3	Nurse Practitioner	354,275	26,241	380,516		380,516		380,516	3
4	Visiting Nurse								4
5	Other Nurse	154,850	11,470	166,320		166,320		166,320	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1 through 9)	568,530	42,111	610,641	-30,833	579,808		579,808	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		28,105	28,105		28,105		28,105	15
16	Transportation (Health Care Staff)								16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		28,105	28,105		28,105		28,105	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	568,530	70,216	638,746	-30,833	607,913		607,913	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	64,738	199,834	264,572	-124,264	140,308		140,308	30
31	Total Facility Overhead (sum of lines 29 and 30)	64,738	199,834	264,572	-124,264	140,308		140,308	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	633,268	270,050	903,318	-155,097	748,221		748,221	32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES **COMPONENT CCN: 14-3413** **WORKSHEET M-2**

Check applicable box: [XX] RHC I [ ] FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.15	293	4,200	630		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	3.14	8,942	2,100	6,594		3
4	Subtotal (sum of lines 1 through 3)	3.29	9,235		7,224	9,235	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	3.29	9,235			9,235	8
9	Physician Services Under Agreements		405			405	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	607,913	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)	607,913	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)	140,308	14
15	Parent provider overhead allocated to facility (see instructions)	468,790	15
16	Total overhead (sum of lines 14 and 15)	609,098	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	609,098	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	609,098	19
20	Total allowable cost of RHC/FQHC sservices(sum of lines 10 and 19)	1,217,011	20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals 'Y'), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES **COMPONENT CCN: 14-3413** **WORKSHEET M-3**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,217,011	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,217,011	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	9,235	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	405	5
6	Total adjusted visits (line 4 plus line 5)	9,640	6
7	Adjusted cost per visit (line 3 divided by line 6)	126.25	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	116.67	116.67		8
9	Rate for program covered visits (see instructions)	126.25	126.25	126.25	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		1,209		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		152,636		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 (see instructions)		152,636		16
16.01	Total program charges (see instructions)(from contractor's records)		160,363		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				16.02
16.03	Total program preventive costs (see instructions)				16.03
16.04	Total program non-preventive costs (see instructions)		100,444		16.04
16.05	Total program cost (see instructions)		100,444		16.05
17	Primary payer payments		91		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		27,081		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		26,656		19
20	Net Medicare cost excluding vaccines (see instructions)		100,353		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				21
22	Total reimbursable Program cost (line 20 plus line 21)		100,353		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		100,353		26
26.01	Sequestration adjustment (see instructions)		2,007		26.01
27	Interim payments		110,921		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		-12,575		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **COMPONENT CCN: 14-3413** **WORKSHEET M-4**

Check applicable boxes: **[XX] RHC I** **[ ] FQHC** **[ ] Title V** **[XX] Title XVIII** **[ ] Title XIX**

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	579,808	579,808	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	607,913	607,913	6
7	Total overhead (from Wkst. M-2, line 16)	609,098	609,098	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries			13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)			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)			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)			16

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/27/2015 Run Time: 11:39 Version: 2015.03 (08/25/2015)

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

COMPONENT CCN: 14-3413

WORKSHEET M-5

Check applicable box: **[XX] RHC I** **[ ] FQHC**

				Part B		
				mm/dd/yyyy	Amount	
	DESCRIPTION			1	2	
1	Total interim payments paid to provider				99,971	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 zero					2
3	List separately each retroactive lump sum adjustment		.01	11/30/2014	10,950	3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter zero (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			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		10,950	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				110,921	
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter zero (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.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)		.01			6.01
	based on the cost report (1)		.02		-10,568	6.02
7	Total Medicare program liability (see instructions)				100,353	

8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.