SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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: 08/26/2017 Time: 10:07 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 04/01/2016 and ending 03/31/2017, 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		274,257	312,567		205,519	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-285,310				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			2,990			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-11,053	315,557		205,519	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.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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									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 / 2016	To: 03 / 31 / 2017	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 is in effect in the cost reporting period.			37
37.01	Is this hospital a former MDH that is eilgible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N		37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:	Ending:	38

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, chapter 21, 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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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, indicate which program year began during this cost reporting period. (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, indicate which program year began during this cost reporting period. (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
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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/IID 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

Rural Providers				1	2	
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 is not made on Wkst. B, Pt. I, col. 25 and the program is 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, chapter 22, 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:	214,558			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.		Y		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
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.		N		122

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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 Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.		N	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, chapter 40, §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.	N		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)			168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)	N		168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition 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)			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 in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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 Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those 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 Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME 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	07/21/2017	Y	07/21/2017	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.	Y	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.	Y	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 services 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: AMBER	Last name: HALSTEAD	Title: PARTNER	41
42	Employer: KERBER, ECK & BRAECKEL, LLP			42
43	Phone number: 618-529-1040	E-mail Address: AMBERH@KEBCPA.COM		43

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	25,992.00		1,040	141	1,546	1
2	HMO and other (see instructions)						103			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						1,093		1,105	5
6	Hospital Adults & Peds. Swing Bed NF								87	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	25,992.00		2,133	141	2,738	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	25,992.00		2,133	141	2,738	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					1,968		11,349	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								239	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)					269	47	419	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)		184.52			269	47	419	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		13.77						26
27	Total (sum of lines 14-26)		198.29						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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA **COMPONENT CCN: 14-3413** **WORKSHEET S-8**

Check applicable box: **[XX] Hospital-Based RHC** **[ ] Hospital-Based FQHC**

Clinic Address and Identification:

1	Street: 1201 RICKER DRIVE	1
2	City: SALEM State: IL ZIP Code: 62881 County: MARION	2
3	HOSPITAL-BASED 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 a hospital-based 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	RHC/FQHC 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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	0.466989	1

Medicaid (see instructions for each line)

2	Net revenue from Medicaid	2,190,236	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	1,277,162	5
6	Medicaid charges	9,617,059	6
7	Medicaid cost (line 1 times line 6)	4,491,061	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.	1,023,663	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)	1,023,663	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	123,353	100,850	224,203	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	57,604	47,096	104,700	21
22	Partial payment by patients approved for charity care	5,641	4,338	9,979	22
23	Cost of charity care (line 21 minus line 22)	51,963	42,758	94,721	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)	913,817	26
27	Medicare bad debts for the entire hospital complex (see instructions)	212,523	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	701,294	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	327,497	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	422,218	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,445,881	31

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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		1,124,020	1,124,020	674,271	1,798,291		1,798,291	1
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2		560,503	560,503		560,503		560,503	1.01
2	00200	Cap Rel Costs-Mvble Equip		599,898	599,898	784,605	1,384,503	-9,853	1,374,650	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	134,221	2,490,170	2,624,391		2,624,391	-100,566	2,523,825	4
5.01	00592	ADMINISTRATIVE & ACCOUNTING	860,724	2,431,350	3,292,074	-684,864	2,607,210	-904,026	1,703,184	5.01
5.02	00591	BUSINESS SERVICES	526,643	352,484	879,127	-5,446	873,681	-29,115	844,566	5.02
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	259,244	678,567	937,811	-25	937,786		937,786	7
8	00800	Laundry & Linen Service	32,436	17,827	50,263		50,263		50,263	8
9	00900	Housekeeping	192,996	88,082	281,078		281,078		281,078	9
10	01000	Dietary	268,856	407,060	675,916	-528,415	147,501	-24,168	123,333	10
11	01100	Cafeteria				526,337	526,337	-109,958	416,379	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	34,592	3,458	38,050		38,050		38,050	13
14	01400	Central Services & Supply								14
14.01	01401	PURCHASING	100,634	31,893	132,527	-1,780	130,747		130,747	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	16,340	403,287	419,627	-419,626	1		1	14.02
15	01500	Pharmacy	44,241	1,377,315	1,421,556	-61,820	1,359,736		1,359,736	15
16	01600	Medical Records & Library	237,045	109,531	346,576		346,576		346,576	16
17	01700	Social Service	73,254	8,992	82,246		82,246		82,246	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	1,828,762	551,827	2,380,589	229,068	2,609,657	-742,607	1,867,050	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	587,130	616,193	1,203,323	-161,167	1,042,156	-91,250	950,906	50
53	05300	Anesthesiology		558,677	558,677	-558,677				53
54	05400	Radiology-Diagnostic	576,590	412,951	989,541	-96,000	893,541	-4,180	889,361	54
57	05700	CT Scan	83,940	86,447	170,387		170,387		170,387	57
58	05800	MRI	100,280	313,042	413,322	-298,800	114,522		114,522	58
60	06000	Laboratory	593,753	1,102,489	1,696,242	-72,266	1,623,976		1,623,976	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	333,954	197,187	531,141	-8,697	522,444	-56,302	466,142	65
66	06600	Physical Therapy		736,862	736,862		736,862		736,862	66
69	06900	Electrocardiology	36,563	40,446	77,009		77,009	-35,061	41,948	69
71	07100	Medical Supplies Charged to Patients				419,626	419,626		419,626	71
72	07200	Impl. Dev. Charged to Patients		962,829	962,829		962,829		962,829	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	1,338,783	322,173	1,660,956	-246,495	1,414,461		1,414,461	88
90	09000	Clinic	210,662	28,366	239,028	-2,592	236,436		236,436	90
90.01	09001	SALEM MEDICAL CLINIC								90.01
91	09100	Emergency	1,002,338	2,176,912	3,179,250	-13,729	3,165,521	-1,048,771	2,116,750	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)	9,473,981	18,790,838	28,264,819	3,508	28,268,327	-3,685,857	24,582,470	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	52,935	49,292	102,227		102,227		102,227	190
192	19200	Physicians' Private Offices	59,073	13,999	73,072	-118	72,954		72,954	192
192.01	19201	TEMPORAILY IDLE SPACE								192.01
192.02	19202	STH FAM HLTH CRT	1,046,476	199,538	1,246,014	-3,390	1,242,624		1,242,624	192.02
200		TOTAL (sum of lines 118-199)	10,632,465	19,053,667	29,686,132		29,686,132	-3,685,857	26,000,275	200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	209,359	316,978	1
500	Total reclassifications				209,359	316,978	500
	Code Letter - A						
1	TO RECLASSIFY SUPPLY COST	B	Medical Supplies Charged to P	71	16,340	403,286	1
500	Total reclassifications				16,340	403,286	500
	Code Letter - B						
1	TO RECLASS RENTALS	C	Cap Rel Costs-Mvble Equip	2		774,311	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					774,311	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	Operating Room	50		28,677	1
500	Total reclassifications					28,677	500
	Code Letter - E						
1	TO RECLASS INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		568,462	1
2			Cap Rel Costs-Mvble Equip	2		10,294	2
500	Total reclassifications					578,756	500
	Code Letter - F						
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G	Rural Health Clinic	88		5,953	1
500	Total reclassifications					5,953	500
	Code Letter - G						
1	TO RECLASS OTHER CAPITAL COSTS	H	Cap Rel Costs-Bldg & Fixt	1		105,809	1
500	Total reclassifications					105,809	500
	Code Letter - H						
1	RECLASS HOSPITALIST SERVICES	K	Adults & Pediatrics	30	217,432	34,904	1
500	Total reclassifications				217,432	34,904	500
	Code Letter - K						
	GRAND TOTAL (Increases)				443,131	2,778,674	

(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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	209,359	316,978		1
500	Total reclassifications				209,359	316,978		500
	Code letter - A							
1	TO RECLASSIFY SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	14.02	16,340	403,286		1
500	Total reclassifications				16,340	403,286		500
	Code letter - B							
1	TO RECLASS RENTALS	C	ADMINISTRATIVE & ACCOUNTING	5.01		299	10	1
2			BUSINESS SERVICES	5.02		5,446		2
3			Operation of Plant	7		25		3
4			Dietary	10		2,078		4
5			PURCHASING	14.01		1,780		5
6			Pharmacy	15		61,820		6
7			Adults & Pediatrics	30		23,268		7
8			Operating Room	50		189,844		8
9			Radiology-Diagnostic	54		96,000		9
10			MRI	58		298,800		10
11			Laboratory	60		72,266		11
12			Respiratory Therapy	65		8,697		12
13			Rural Health Clinic	88		112		13
14			Clinic	90		2,592		14
15			Emergency	91		7,776		15
16			Physicians' Private Offices	192		118		16
17			STH FAM HLTH CRT	192.02		3,390		17
500	Total reclassifications					774,311		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	Anesthesiology	53		28,677		1
500	Total reclassifications					28,677		500
	Code letter - E							
1	TO RECLASS INTEREST EXPENSE	F	ADMINISTRATIVE & ACCOUNTING	5.01		578,756	14	1
2							14	2
500	Total reclassifications					578,756		500
	Code letter - F							
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G	Emergency	91		5,953		1
500	Total reclassifications					5,953		500
	Code letter - G							
1	TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	5.01		105,809	14	1
500	Total reclassifications					105,809		500
	Code letter - H							
1	RECLASS HOSPITALIST SERVICES	K	Rural Health Clinic	88	217,432	34,904		1
500	Total reclassifications				217,432	34,904		500
	Code letter - K							
	GRAND TOTAL (Decreases)				443,131	2,778,674		

(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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	134,755					134,755		1
2	Land Improvements	1,171,121	8,938		8,938		1,180,059		2
3	Buildings and Fixtures	35,103,376	156,043		156,043	74,141	35,185,278		3
4	Building Improvements								4
5	Fixed Equipment	2,745,942	3,398		3,398		2,749,340		5
6	Movable Equipment	9,367,630	525,140		525,140	332,051	9,560,719		6
7	HIT-designated Assets	1,079,269					1,079,269		7
8	Subtotal (sum of lines 1-7)	49,602,093	693,519		693,519	406,192	49,889,420		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	49,602,093	693,519		693,519	406,192	49,889,420		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	1,124,020						1,124,020	1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	560,503						560,503	1.01
2	Cap Rel Costs-Mvble Equip	599,898						599,898	2
3	Total (sum of lines 1-2)	2,284,421						2,284,421	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
1.01	NEW CAP-REL CSTS-BLDGS				0.000000					1.01
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	1,124,020					674,271	1,798,291	1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	560,503						560,503	1.01
2	Cap Rel Costs-Mvble Equip	599,898	774,311				441	1,374,650	2
3	Total (sum of lines 1-2)	2,284,421	774,311				674,712	3,733,444	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	-10,619	ADMINISTRATIVE & ACCOUNTING	5.01		3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-1,304	BUSINESS SERVICES	5.02		7
8	Television and radio service (chapter 21)	A	-2,542	ADMINISTRATIVE & ACCOUNTING	5.01		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,978,171				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	-109,958	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						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	-7,097	Cap Rel Costs-Mvble Equip	2	14	32
33	TELEPHONE	A	-2,505	BUSINESS SERVICES	5.02		33
34	DIETARY REVENUE	B	-24,168	Dietary	10		34
35	BUS OFFICE COSTS ASSOC W/ PHYS CHG	A	-25,306	BUSINESS SERVICES	5.02		35
36							36
37	PHYSICIAN RECRUITMENT	A	-2,389	ADMINISTRATIVE & ACCOUNTING	5.01		37
38	OTHER REVENUE	B	-2,102	ADMINISTRATIVE & ACCOUNTING	5.01		38
39	LOBBYING PORTION OF DUES	A	-12,102	ADMINISTRATIVE & ACCOUNTING	5.01		39
40	MARKETING	A	-100,566	Employee Benefits Department	4		40
41	OTHER REVENUE	B	-1,771	ADMINISTRATIVE & ACCOUNTING	5.01		41
42							42
43	GOODWILL AMORTIZATION- PHY. CLINIC	A	-294,288	ADMINISTRATIVE & ACCOUNTING	5.01		43
44	IMPAIRED ASSETS	A	-2,756	Cap Rel Costs-Mvble Equip	2	14	44
45	LEGAL FEES	A	-578,213	ADMINISTRATIVE & ACCOUNTING	5.01		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)		-3,685,857				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.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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:

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	91,250	91,250						1
2	60	Laboratory LABORATORY	58,138		58,138					2
3	65	Respiratory Therapy RESPIRATORY THE	56,302	56,302						3
4	69	Electrocardiology ELECTROCARDIOLO	35,061	35,061						4
5	91	Emergency EMERGENCY	2,000,325	1,048,771	951,554					5
6	30	Adults & Pediatrics HOSPITALIST	742,607	742,607						6
7	54	Radiology-Diagnostic ECHOCARDIOLOGY	4,180	4,180						7
8	53	Anesthesiology ANESTHESIOLOGY	24,000		24,000					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	3,011,863	1,978,171	1,033,692					200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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							91,250	1
2	60	Laboratory LABORATORY								2
3	65	Respiratory Therapy RESPIRATORY THE							56,302	3
4	69	Electrocardiology ELECTROCARDIOLO							35,061	4
5	91	Emergency EMERGENCY							1,048,771	5
6	30	Adults & Pediatrics HOSPITALIST							742,607	6
7	54	Radiology-Diagnostic ECHOCARDIOLOGY							4,180	7
8	53	Anesthesiology ANESTHESIOLOGY								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							1,978,171	200

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)					12	1
2	Line 1 multiplied by 15 hours per week					180	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					5.35	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		1,496.41				9
10	AHSEA (see instructions)		76.95				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)	38.48	38.48				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)	115,149	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)	115,149	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)	115,149	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)	115,149	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	115,149	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)	115,149	63
64	Total cost of outside supplier services (from provider records)	103,949	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)					12	1
2	Line 1 multiplied by 15 hours per week					180	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					5.35	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	867.59	4,237.50		5,875.55		9
10	AHSEA (see instructions)	47.27	81.19		60.89		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)	40.60	40.60				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)	41,011	14
15	Therapists (column 2, line 9 times column 2, line 10)	344,043	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)	385,054	17
18	Aides (column 4, line 9 times column 4, line 10)	357,762	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)	742,816	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)	742,816	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	742,816	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)	742,816	63
64	Total cost of outside supplier services (from provider records)	563,179	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)					4	1
2	Line 1 multiplied by 15 hours per week					60	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					5.35	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		9.50				9
10	AHSEA (see instructions)		73.94				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)	36.97	36.97				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)	702	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)	702	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)	702	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)	73.89	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	4,433	22
23	Total salary equivalency (see instructions)	4,433	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	4,433	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)	4,433	63
64	Total cost of outside supplier services (from provider records)	513	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES		CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	
		0	1	1.01	2	4	4A	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,798,291	1,798,291					1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	560,503		560,503				1.01
2	Cap Rel Costs-Mvble Equip	1,374,650			1,374,650			2
4	Employee Benefits Department	2,523,825	13,554		1,881	2,539,260		4
5.01	ADMINISTRATIVE & ACCOUNTING	1,703,184	359,169	31,977	12,034	208,188	2,314,552	5.01
5.02	BUSINESS SERVICES	844,566	100,705	658	148,238	127,382	1,221,549	5.02
6	Maintenance & Repairs							6
7	Operation of Plant	937,786	458,119	27,141	21,936	62,705	1,507,687	7
8	Laundry & Linen Service	50,263	14,204			7,845	72,312	8
9	Housekeeping	281,078	11,801			46,681	339,560	9
10	Dietary	123,333	37,394		3,334	14,391	178,452	10
11	Cafeteria	416,379	20,418			50,639	487,436	11
12	Maintenance of Personnel							12
13	Nursing Administration	38,050	5,846		694	8,367	52,957	13
14	Central Services & Supply							14
14.01	PURCHASING	130,747	21,219		2,248	24,341	178,555	14.01
14.02	CENTRAL SERVICES & SUPPLY	1					1	14.02
15	Pharmacy	1,359,736		18,801	62,248	10,701	1,451,486	15
16	Medical Records & Library	346,576	20,115		2,200	57,335	426,226	16
17	Social Service	82,246				17,718	99,964	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	1,867,050		265,522	78,298	494,919	2,705,789	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	950,906	133,465		244,794	142,012	1,471,177	50
53	Anesthesiology							53
54	Radiology-Diagnostic	889,361	117,919		200,540	139,463	1,347,283	54
57	CT Scan	170,387	10,025		110,397	20,303	311,112	57
58	MRI	114,522	7,297		298,896	24,255	444,970	58
60	Laboratory	1,623,976	78,057		94,522	143,614	1,940,169	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	466,142	39,645	18,291	23,464	80,775	628,317	65
66	Physical Therapy	736,862	110,492		3,532		850,886	66
69	Electrocardiology	41,948		7,303	8,896	8,844	66,991	69
71	Medical Supplies Charged to Patients	419,626		10,939	414	3,952	434,931	71
72	Impl. Dev. Charged to Patients	962,829					962,829	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	1,414,461		75,781	7,423	271,227	1,768,892	88
90	Clinic	236,436	50,060	6,020	8,493	50,954	351,963	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	2,116,750	91,936		21,392	242,441	2,472,519	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)	24,582,470	1,701,440	462,433	1,355,874	2,259,052	24,088,565	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	102,227	18,383		2,956	12,804	136,370	190
192	Physicians' Private Offices	72,954		98,070	9,481	14,288	194,793	192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	1,242,624	78,468		6,339	253,116	1,580,547	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	26,000,275	1,798,291	560,503	1,374,650	2,539,260	26,000,275	202

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

	COST CENTER DESCRIPTIONS	ADMINISTRATIVE & ACCOUNTING	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.01	5.02	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING	2,314,552						5.01
5.02	BUSINESS SERVICES	119,369	1,340,918					5.02
6	Maintenance & Repairs							6
7	Operation of Plant	147,330		1,655,017				7
8	Laundry & Linen Service	7,066		15,406	94,784			8
9	Housekeeping	33,181		12,799	13,591	399,131		9
10	Dietary	17,438		40,559	980	16,984	254,413	10
11	Cafeteria	47,632		22,146				11
12	Maintenance of Personnel							12
13	Nursing Administration	5,175		6,341				13
14	Central Services & Supply							14
14.01	PURCHASING	17,448		23,015				14.01
14.02	CENTRAL SERVICES & SUPPLY					5,564		14.02
15	Pharmacy	141,838		26,843		4,978		15
16	Medical Records & Library	41,650		21,818		2,635		16
17	Social Service	9,768						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	264,415	75,221	379,096	38,724	120,357	254,413	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	143,762	109,135	144,762	15,151	26,355		50
53	Anesthesiology		157					53
54	Radiology-Diagnostic	131,655	123,477	127,900	10,127	28,698		54
57	CT Scan	30,402	226,977	10,874		4,392		57
58	MRI	43,482	46,494	7,914		1,171		58
60	Laboratory	189,591	266,576	84,664		29,576		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	61,399	75,297	69,117		15,813		65
66	Physical Therapy	83,148	94,329	119,844	2,873	5,857		66
69	Electrocardiology	6,546	20,203	10,427				69
71	Medical Supplies Charged to Patients	42,501	35,748	15,618				71
72	Impl. Dev. Charged to Patients	94,087	31,251					72
73	Drugs Charged to Patients		66,821					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	172,854	39,282	108,196		24,012		88
90	Clinic	34,393	8,726	62,893				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	241,612	121,224	99,718	13,338	48,317		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)	2,127,742	1,340,918	1,409,950	94,784	334,709	254,413	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	13,326		19,939		7,906		190
192	Physicians' Private Offices	19,035		140,018		31,040		192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	154,449		85,110		25,476		192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,314,552	1,340,918	1,655,017	94,784	399,131	254,413	202

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14.01	14.02	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
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	557,214						11
12	Maintenance of Personnel							12
13	Nursing Administration	667	65,140					13
14	Central Services & Supply							14
14.01	PURCHASING	8,711		227,729				14.01
14.02	CENTRAL SERVICES & SUPPLY			239	5,804			14.02
15	Pharmacy	6,400		575		1,632,120		15
16	Medical Records & Library	30,976		599			523,904	16
17	Social Service	5,422		3				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	135,726	28,301	10,640			95,072	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	44,709	9,339	39,476	64		56,842	50
53	Anesthesiology							53
54	Radiology-Diagnostic	47,553		15,123				54
57	CT Scan	6,355		5,247				57
58	MRI	8,088		1,326				58
60	Laboratory	65,508		128,279			148,395	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	32,665		3,334			32,445	65
66	Physical Therapy			1,047			43,260	66
69	Electrocardiology			507			13,582	69
71	Medical Supplies Charged to Patients	2,755			1,638			71
72	Impl. Dev. Charged to Patients				3,937			72
73	Drugs Charged to Patients					1,632,120		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	59,019	12,261	3,508			24,145	88
90	Clinic	14,888		1,133	2			90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	73,240	15,239	11,049	1		110,163	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)	542,682	65,140	222,085	5,642	1,632,120	523,904	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8,177		1,144	162			190
192	Physicians' Private Offices	6,355		1,385				192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT			3,115				192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	557,214	65,140	227,729	5,804	1,632,120	523,904	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		17	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
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	115,157						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	115,157	4,222,911		4,222,911			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,060,772		2,060,772			50
53	Anesthesiology		157		157			53
54	Radiology-Diagnostic		1,831,816		1,831,816			54
57	CT Scan		595,359		595,359			57
58	MRI		553,445		553,445			58
60	Laboratory		2,852,758		2,852,758			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		918,387		918,387			65
66	Physical Therapy		1,201,244		1,201,244			66
69	Electrocardiology		118,256		118,256			69
71	Medical Supplies Charged to Patients		533,191		533,191			71
72	Impl. Dev. Charged to Patients		1,092,104		1,092,104			72
73	Drugs Charged to Patients		1,698,941		1,698,941			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		2,212,169		2,212,169			88
90	Clinic		473,998		473,998			90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency		3,206,420		3,206,420			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)	115,157	23,571,928		23,571,928			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		187,024		187,024			190
192	Physicians' Private Offices		392,626		392,626			192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		1,848,697		1,848,697			192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	115,157	26,000,275		26,000,275			202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	
		0	1	1.01	2	2A	4	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		13,554		1,881	15,435	15,435	4
5.01	ADMINISTRATIVE & ACCOUNTING		359,169	31,977	12,034	403,180	1,265	5.01
5.02	BUSINESS SERVICES		100,705	658	148,238	249,601	774	5.02
6	Maintenance & Repairs							6
7	Operation of Plant		458,119	27,141	21,936	507,196	381	7
8	Laundry & Linen Service		14,204			14,204	48	8
9	Housekeeping		11,801			11,801	284	9
10	Dietary		37,394		3,334	40,728	87	10
11	Cafeteria		20,418			20,418	308	11
12	Maintenance of Personnel							12
13	Nursing Administration		5,846		694	6,540	51	13
14	Central Services & Supply							14
14.01	PURCHASING		21,219		2,248	23,467	148	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy			18,801	62,248	81,049	65	15
16	Medical Records & Library		20,115		2,200	22,315	348	16
17	Social Service						108	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			265,522	78,298	343,820	3,011	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		133,465		244,794	378,259	863	50
53	Anesthesiology							53
54	Radiology-Diagnostic		117,919		200,540	318,459	848	54
57	CT Scan		10,025		110,397	120,422	123	57
58	MRI		7,297		298,896	306,193	147	58
60	Laboratory		78,057		94,522	172,579	873	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		39,645	18,291	23,464	81,400	491	65
66	Physical Therapy		110,492		3,532	114,024		66
69	Electrocardiology			7,303	8,896	16,199	54	69
71	Medical Supplies Charged to Patients			10,939	414	11,353	24	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			75,781	7,423	83,204	1,648	88
90	Clinic		50,060	6,020	8,493	64,573	310	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency		91,936		21,392	113,328	1,473	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)		1,701,440	462,433	1,355,874	3,519,747	13,732	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		18,383		2,956	21,339	78	190
192	Physicians' Private Offices			98,070	9,481	107,551	87	192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		78,468		6,339	84,807	1,538	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,798,291	560,503	1,374,650	3,733,444	15,435	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ADMINISTRATIVE & ACCOUNTING	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.01	5.02	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING	404,445						5.01
5.02	BUSINESS SERVICES	20,858	271,233					5.02
6	Maintenance & Repairs							6
7	Operation of Plant	25,744		533,321				7
8	Laundry & Linen Service	1,235		4,965	20,452			8
9	Housekeeping	5,798		4,125	2,933	24,941		9
10	Dietary	3,047		13,070	211	1,061	58,204	10
11	Cafeteria	8,323		7,137				11
12	Maintenance of Personnel							12
13	Nursing Administration	904		2,043				13
14	Central Services & Supply							14
14.01	PURCHASING	3,049		7,417				14.01
14.02	CENTRAL SERVICES & SUPPLY					348		14.02
15	Pharmacy	24,784		8,650		311		15
16	Medical Records & Library	7,278		7,031		165		16
17	Social Service	1,707						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	46,212	15,214	122,161	8,356	7,522	58,204	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	25,120	22,073	46,649	3,269	1,647		50
53	Anesthesiology		32					53
54	Radiology-Diagnostic	23,005	24,974	41,215	2,185	1,793		54
57	CT Scan	5,312	45,908	3,504		274		57
58	MRI	7,598	9,404	2,550		73		58
60	Laboratory	33,128	53,939	27,282		1,848		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	10,729	15,229	22,272		988		65
66	Physical Therapy	14,529	19,079	38,619	620	366		66
69	Electrocardiology	1,144	4,086	3,360				69
71	Medical Supplies Charged to Patients	7,426	7,230	5,033				71
72	Impl. Dev. Charged to Patients	16,440	6,321					72
73	Drugs Charged to Patients		13,515					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	30,204	7,945	34,866		1,500		88
90	Clinic	6,010	1,765	20,267				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	42,218	24,519	32,134	2,878	3,019		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)	371,802	271,233	454,350	20,452	20,915	58,204	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,329		6,425		494		190
192	Physicians' Private Offices	3,326		45,120		1,940		192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	26,988		27,426		1,592		192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	404,445	271,233	533,321	20,452	24,941	58,204	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS-TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14.01	14.02	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
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	36,186						11
12	Maintenance of Personnel							12
13	Nursing Administration	43	9,581					13
14	Central Services & Supply							14
14.01	PURCHASING	566		34,647				14.01
14.02	CENTRAL SERVICES & SUPPLY			36	384			14.02
15	Pharmacy	416		87		115,362		15
16	Medical Records & Library	2,012		91			39,240	16
17	Social Service	352						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	8,814	4,163	1,619			7,121	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,903	1,374	6,006	4		4,257	50
53	Anesthesiology							53
54	Radiology-Diagnostic	3,088		2,301				54
57	CT Scan	413		798				57
58	MRI	525		202				58
60	Laboratory	4,254		19,518			11,116	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,121		507			2,430	65
66	Physical Therapy			159			3,240	66
69	Electrocardiology			77			1,017	69
71	Medical Supplies Charged to Patients	179			108			71
72	Impl. Dev. Charged to Patients				261			72
73	Drugs Charged to Patients					115,362		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	3,833	1,803	534			1,808	88
90	Clinic	967		172				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	4,756	2,241	1,681			8,251	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)	35,242	9,581	33,788	373	115,362	39,240	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	531		174	11			190
192	Physicians' Private Offices	413		211				192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT			474				192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	36,186	9,581	34,647	384	115,362	39,240	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL			
		17	24	25	26			
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
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	2,167						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	2,167	628,384		628,384			30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		492,424		492,424			50
53	Anesthesiology		32		32			53
54	Radiology-Diagnostic		417,868		417,868			54
57	CT Scan		176,754		176,754			57
58	MRI		326,692		326,692			58
60	Laboratory		324,537		324,537			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		136,167		136,167			65
66	Physical Therapy		190,636		190,636			66
69	Electrocardiology		25,937		25,937			69
71	Medical Supplies Charged to Patients		31,353		31,353			71
72	Impl. Dev. Charged to Patients		23,022		23,022			72
73	Drugs Charged to Patients		128,877		128,877			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		167,345		167,345			88
90	Clinic		94,064		94,064			90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency		236,498		236,498			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)	2,167	3,400,590		3,400,590			118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		31,381		31,381			190
192	Physicians' Private Offices		158,648		158,648			192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		142,825		142,825			192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,167	3,733,444		3,733,444			202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON-CILIATION	ADMINISTRATIVE & ACCOUNTING ACCUM COST	
		1	1.01	2	4	5A.01	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	83,053						1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2		34,075					1.01
2	Cap Rel Costs-Mvble Equip			1,374,210				2
4	Employee Benefits Department	626		1,880	10,498,244			4
5.01	ADMINISTRATIVE & ACCOUNTING	16,588	1,944	12,030	860,724	-2,314,552	23,685,723	5.01
5.02	BUSINESS SERVICES	4,651	40	148,191	526,643		1,221,549	5.02
6	Maintenance & Repairs							6
7	Operation of Plant	21,158	1,650	21,929	259,244		1,507,687	7
8	Laundry & Linen Service	656			32,436		72,312	8
9	Housekeeping	545			192,996		339,560	9
10	Dietary	1,727		3,333	59,497		178,452	10
11	Cafeteria	943			209,359		487,436	11
12	Maintenance of Personnel							12
13	Nursing Administration	270		694	34,592		52,957	13
14	Central Services & Supply							14
14.01	PURCHASING	980		2,247	100,634		178,555	14.01
14.02	CENTRAL SERVICES & SUPPLY						1	14.02
15	Pharmacy		1,143	62,228	44,241		1,451,486	15
16	Medical Records & Library	929		2,199	237,045		426,226	16
17	Social Service				73,254		99,964	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		16,142	78,273	2,046,194		2,705,789	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,164		244,716	587,130		1,471,177	50
53	Anesthesiology							53
54	Radiology-Diagnostic	5,446		200,476	576,590		1,347,283	54
57	CT Scan	463		110,362	83,940		311,112	57
58	MRI	337		298,800	100,280		444,970	58
60	Laboratory	3,605		94,492	593,753		1,940,169	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,831	1,112	23,456	333,954		628,317	65
66	Physical Therapy	5,103		3,531			850,886	66
69	Electrocardiology		444	8,893	36,563		66,991	69
71	Medical Supplies Charged to Patients		665	414	16,340		434,931	71
72	Impl. Dev. Charged to Patients						962,829	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		4,607	7,421	1,121,351		1,768,892	88
90	Clinic	2,312	366	8,490	210,662		351,963	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	4,246		21,385	1,002,338		2,472,519	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)	78,580	28,113	1,355,440	9,339,760	-2,314,552	21,774,013	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	849		2,955	52,935		136,370	190
192	Physicians' Private Offices		5,962	9,478	59,073		194,793	192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	3,624		6,337	1,046,476		1,580,547	192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,798,291	560,503	1,374,650	2,539,260		2,314,552	202
203	Unit Cost Multiplier (Wkst. B, Part I)	21.652330	16.449098	1.000320	0.241875		0.097719	203
204	Cost to be allocated (Per Wkst. B, Part II)				15,435		404,445	204
205	Unit Cost Multiplier (Wkst. B, Part II)				0.001470		0.017075	205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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

	COST CENTER DESCRIPTIONS	BUSINESS SERVICES GROSS CHARGES	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	
		5.02	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES	50,476,374						5.02
6	Maintenance & Repairs							6
7	Operation of Plant		70,471					7
8	Laundry & Linen Service		656	16,828				8
9	Housekeeping		545	2,413	1,363			9
10	Dietary		1,727	174	58	4,593		10
11	Cafeteria		943				12,538	11
12	Maintenance of Personnel							12
13	Nursing Administration		270				15	13
14	Central Services & Supply							14
14.01	PURCHASING		980				196	14.01
14.02	CENTRAL SERVICES & SUPPLY				19			14.02
15	Pharmacy		1,143		17		144	15
16	Medical Records & Library		929		9		697	16
17	Social Service						122	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	2,831,586	16,142	6,875	411	4,593	3,054	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,108,208	6,164	2,690	90		1,006	50
53	Anesthesiology	5,912						53
54	Radiology-Diagnostic	4,648,123	5,446	1,798	98		1,070	54
57	CT Scan	8,544,227	463		15		143	57
58	MRI	1,750,184	337		4		182	58
60	Laboratory	10,034,354	3,605		101		1,474	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,834,443	2,943		54		735	65
66	Physical Therapy	3,550,859	5,103	510	20			66
69	Electrocardiology	760,518	444					69
71	Medical Supplies Charged to Patients	1,345,698	665				62	71
72	Impl. Dev. Charged to Patients	1,176,407						72
73	Drugs Charged to Patients	2,515,361						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	1,478,715	4,607		82		1,328	88
90	Clinic	328,482	2,678				335	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	4,563,297	4,246	2,368	165		1,648	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)	50,476,374	60,036	16,828	1,143	4,593	12,211	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		849		27		184	190
192	Physicians' Private Offices		5,962		106		143	192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		3,624		87			192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,340,918	1,655,017	94,784	399,131	254,413	557,214	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.026565	23.485079	5.632517	292.832722	55.391465	44.442016	203
204	Cost to be allocated (Per Wkst. B, Part II)	271,233	533,321	20,452	24,941	58,204	36,186	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.005373	7.567950	1.215355	18.298606	12.672327	2.886106	205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
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	152,156						13
14	Central Services & Supply							14
14.01	PURCHASING		1,151,798					14.01
14.02	CENTRAL SERVICES & SUPPLY		1,210	1,419,658				14.02
15	Pharmacy		2,906		1,000			15
16	Medical Records & Library		3,028			2,083		16
17	Social Service		15				2,179	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	66,108	53,816			378	2,179	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	21,814	199,662	15,637		226		50
53	Anesthesiology							53
54	Radiology-Diagnostic		76,489					54
57	CT Scan		26,537	59				57
58	MRI		6,709					58
60	Laboratory		648,795			590		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		16,865			129		65
66	Physical Therapy		5,298	104		172		66
69	Electrocardiology		2,563			54		69
71	Medical Supplies Charged to Patients			400,774				71
72	Impl. Dev. Charged to Patients			962,829				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	28,639	17,744	32		96		88
90	Clinic		5,731	431				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	35,595	55,881	201		438		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)	152,156	1,123,249	1,380,067	1,000	2,083	2,179	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,786	39,591				190
192	Physicians' Private Offices		7,006					192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		15,757					192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	65,140	227,729	5,804	1,632,120	523,904	115,157	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.428113	0.197716	0.004088	1,632.120000	251.514162	52.848554	203
204	Cost to be allocated (Per Wkst. B, Part II)	9,581	34,647	384	115,362	39,240	2,167	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.062968	0.030081	0.000270	115.362000	18.838214	0.994493	205

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

	COST CENTER DESCRIPTIONS							

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
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
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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	4,222,911		4,222,911			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	2,060,772		2,060,772			50
53	Anesthesiology	157		157			53
54	Radiology-Diagnostic	1,831,816		1,831,816			54
57	CT Scan	595,359		595,359			57
58	MRI	553,445		553,445			58
60	Laboratory	2,852,758		2,852,758			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	918,387		918,387			65
66	Physical Therapy	1,201,244		1,201,244			66
69	Electrocardiology	118,256		118,256			69
71	Medical Supplies Charged to Patients	533,191		533,191			71
72	Impl. Dev. Charged to Patients	1,092,104		1,092,104			72
73	Drugs Charged to Patients	1,698,941		1,698,941			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	2,212,169		2,212,169			88
90	Clinic	473,998		473,998			90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	3,206,420		3,206,420			91
92	Observation Beds (Non-Distinct Part)	348,364		348,364			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)	23,920,292		23,920,292			200
201	Less Observation Beds	348,364		348,364			201
202	Total (line 200 minus line 201)	23,571,928		23,571,928			202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	2,535,647		2,535,647				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	647,578	3,460,630	4,108,208	0.501623			50
53	Anesthesiology	3,458	2,455	5,913	0.026552			53
54	Radiology-Diagnostic	248,428	4,399,695	4,648,123	0.394098			54
57	CT Scan	257,816	8,286,410	8,544,226	0.069680			57
58	MRI	19,953	1,730,231	1,750,184	0.316221			58
60	Laboratory	922,303	9,112,051	10,034,354	0.284299			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,066,148	1,768,296	2,834,444	0.324010			65
66	Physical Therapy	909,906	2,640,953	3,550,859	0.338297			66
69	Electrocardiology	20,302	740,216	760,518	0.155494			69
71	Medical Supplies Charged to Patients	404,201	941,497	1,345,698	0.396219			71
72	Impl. Dev. Charged to Patients	933,178	243,230	1,176,408	0.928338			72
73	Drugs Charged to Patients	738,162	1,777,199	2,515,361	0.675426			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		1,478,715	1,478,715				88
90	Clinic	201	328,281	328,482	1.442995			90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	1,788	4,561,509	4,563,297	0.702654			91
92	Observation Beds (Non-Distinct Part)		295,939	295,939	1.177148			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)	8,709,069	41,767,307	50,476,376				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	8,709,069	41,767,307	50,476,376				202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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**
[XX] Title XVIII, Part B **[ ] IPF** **[ ] SNF** **[ ] Swing Bed NF**
[ ] Title XIX - O/P **[ ] IRF** **[ ] NF** **[ ] ICF/IID**

			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	0.501623		1,906,654			956,421		50
53	Anesthesiology	0.026552							53
54	Radiology-Diagnostic	0.394098		1,792,467			706,408		54
57	CT Scan	0.069680		3,256,613			226,921		57
58	MRI	0.316221		644,154			203,695		58
60	Laboratory	0.284299		3,304,047			939,337		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.324010		731,464			237,002		65
66	Physical Therapy	0.338297		1,024,730			346,663		66
69	Electrocardiology	0.155494		367,565			57,154		69
71	Medical Supplies Charged to Pat	0.396219		398,255			157,796		71
72	Impl. Dev. Charged to Patients	0.928338		150,986			140,166		72
73	Drugs Charged to Patients	0.675426		793,574			536,001		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	1.442995		193,345			278,996		90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.702654		1,452,392			1,020,529		91
92	Observation Beds (Non-Distinct	1.177148		126,017			148,341		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			16,142,263			5,955,430		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			16,142,263			5,955,430		202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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/IID**

			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	0.501623							50
53	Anesthesiology	0.026552							53
54	Radiology-Diagnostic	0.394098							54
57	CT Scan	0.069680							57
58	MRI	0.316221							58
60	Laboratory	0.284299							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.324010							65
66	Physical Therapy	0.338297							66
69	Electrocardiology	0.155494							69
71	Medical Supplies Charged to Pat	0.396219							71
72	Impl. Dev. Charged to Patients	0.928338							72
73	Drugs Charged to Patients	0.675426							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	1.442995							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.702654							91
92	Observation Beds (Non-Distinct	1.177148							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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	628,384	241,228	387,156	1,785	216.89	141	30,581	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)	628,384		387,156	1,785		141	30,581	200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	492,424	4,108,208	0.119863			50
53	Anesthesiology	32	5,913	0.005412			53
54	Radiology-Diagnostic	417,868	4,648,123	0.089900			54
57	CT Scan	176,754	8,544,226	0.020687			57
58	MRI	326,692	1,750,184	0.186662			58
60	Laboratory	324,537	10,034,354	0.032343			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	136,167	2,834,444	0.048040			65
66	Physical Therapy	190,636	3,550,859	0.053687			66
69	Electrocardiology	25,937	760,518	0.034104			69
71	Medical Supplies Charged to Pat	31,353	1,345,698	0.023299			71
72	Impl. Dev. Charged to Patients	23,022	1,176,408	0.019570			72
73	Drugs Charged to Patients	128,877	2,515,361	0.051236			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	167,345	1,478,715	0.113169			88
90	Clinic	94,064	328,482	0.286360			90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	236,498	4,563,297	0.051826			91
92	Observation Beds (Non-Distinct	51,838	295,939	0.175164			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,824,044	47,940,729				200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	1,785		141		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)	1,785		141		200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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

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

(A)	Cost Center Description	Non Physician Anesth-etist Cost 1	Nursing School 2	Allied Health 3	All Other Medical Education Cost 4	Total Cost (sum of col. 1 through col. 4) 5	Total Outpatient Cost (sum of col. 2, 3, and 4) 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
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							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							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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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

Check Applicable Boxes: [ ] Title V [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [ ] PPS
[ ] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA
[XX] Title XIX [ ] IRF [ ] NF [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	4,108,208							50
53	Anesthesiology	5,913							53
54	Radiology-Diagnostic	4,648,123							54
57	CT Scan	8,544,226							57
58	MRI	1,750,184							58
60	Laboratory	10,034,354							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,834,444							65
66	Physical Therapy	3,550,859							66
69	Electrocardiology	760,518							69
71	Medical Supplies Charged to Pat	1,345,698							71
72	Impl. Dev. Charged to Patients	1,176,408							72
73	Drugs Charged to Patients	2,515,361							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	1,478,715							88
90	Clinic	328,482							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	4,563,297							91
92	Observation Beds (Non-Distinct	295,939							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	47,940,729							200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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/IID**

			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	0.501623							50
53	Anesthesiology	0.026552							53
54	Radiology-Diagnostic	0.394098							54
57	CT Scan	0.069680							57
58	MRI	0.316221							58
60	Laboratory	0.284299							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.324010							65
66	Physical Therapy	0.338297							66
69	Electrocardiology	0.155494							69
71	Medical Supplies Charged to Pat	0.396219							71
72	Impl. Dev. Charged to Patients	0.928338							72
73	Drugs Charged to Patients	0.675426							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	1.442995							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.702654							91
92	Observation Beds (Non-Distinct	1.177148							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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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/IID**	**[ ] 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)	2,977	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,785	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)	1,546	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	921	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)	184	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	73	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)	14	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,040	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)	911	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)	182	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)	4,222,911	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)	8,806	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,689	25
26	Total swing-bed cost (see instructions)	1,621,121	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,601,790	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)	2,601,790	37

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	1,457.58	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,515,883	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)	1,515,883	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)	1,630,810	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	3,146,693	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)	1,327,855	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	265,280	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)	1,593,135	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/IID [ ] 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)					239	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,457.59	88
89	Observation bed cost (line 87 x line 88) (see instructions)					348,364	89
		Cost	Routine Cost (from line 21)	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	628,384	4,222,911	0.148804	348,364	51,838	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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/IID**	**[ ] 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)	2,977	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,785	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)	1,546	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	921	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)	184	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	73	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)	14	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	141	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)	4,222,911	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)	8,806	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,689	25
26	Total swing-bed cost (see instructions)	1,621,121	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,601,790	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)	2,601,790	37

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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

		1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS		
38	Adjusted general inpatient routine service cost per diem (see instructions)	1,457.58	38
39	Program general inpatient routine service cost (line 9 x line 38)	205,519	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)	205,519	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)	205,519	49
	PASS THROUGH COST ADJUSTMENTS		
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	30,581	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)	30,581	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)	239	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 21)	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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

Check Applicable Boxes:
[ ] Title V **[XX] Title XVIII, Part A** **[ ] Title XIX**
[XX] Hospital **[ ] IPF** **[ ] IRF**
[ ] SUB (Other) **[ ] SNF** **[ ] NF**
[ ] Swing Bed SNF **[ ] Swing Bed NF** **[ ] ICF/IID**
[ ] 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		1,147,857		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.501623	406,804	204,062	50
53	Anesthesiology	0.026552			53
54	Radiology-Diagnostic	0.394098	155,080	61,117	54
57	CT Scan	0.069680	128,811	8,976	57
58	MRI	0.316221	12,844	4,062	58
60	Laboratory	0.284299	539,989	153,518	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.324010	641,224	207,763	65
66	Physical Therapy	0.338297	114,896	38,869	66
69	Electrocardiology	0.155494	13,518	2,102	69
71	Medical Supplies Charged to Patients	0.396219	258,360	102,367	71
72	Impl. Dev. Charged to Patients	0.928338	639,356	593,538	72
73	Drugs Charged to Patients	0.675426	374,845	253,180	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	1.442995			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.702654	1,788	1,256	91
92	Observation Beds (Non-Distinct Part)	1.177148			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,287,515	1,630,810	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,287,515		202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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/IID**
[ ] 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	0.501623			50
53	Anesthesiology	0.026552			53
54	Radiology-Diagnostic	0.394098	17,062	6,724	54
57	CT Scan	0.069680	10,052	700	57
58	MRI	0.316221			58
60	Laboratory	0.284299	111,519	31,705	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.324010	85,750	27,784	65
66	Physical Therapy	0.338297	704,591	238,361	66
69	Electrocardiology	0.155494	840	131	69
71	Medical Supplies Charged to Patients	0.396219	91,806	36,375	71
72	Impl. Dev. Charged to Patients	0.928338			72
73	Drugs Charged to Patients	0.675426	150,514	101,661	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	1.442995			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.702654			91
92	Observation Beds (Non-Distinct Part)	1.177148			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,172,134	443,441	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,172,134		202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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/IID**	**[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	0.501623			50
53	Anesthesiology	0.026552			53
54	Radiology-Diagnostic	0.394098			54
57	CT Scan	0.069680			57
58	MRI	0.316221			58
60	Laboratory	0.284299			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.324010			65
66	Physical Therapy	0.338297			66
69	Electrocardiology	0.155494			69
71	Medical Supplies Charged to Patients	0.396219			71
72	Impl. Dev. Charged to Patients	0.928338			72
73	Drugs Charged to Patients	0.675426			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	1.442995			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.702654			91
92	Observation Beds (Non-Distinct Part)	1.177148			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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	5,955,430			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)	5,955,430			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)	6,014,984			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)	58,579			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,548,324			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)	3,408,081			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)	3,408,081			30
31	Primary payer payments	863			31
32	Subtotal (line 30 minus line 31)	3,407,218			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)	289,344			34
35	Adjusted reimbursable bad debts (see instructions)	188,074			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	289,344			36
37	Subtotal (see instructions)	3,595,292			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)	3,595,292			40
40.01	Sequestration adjustment (see instructions)	71,906			40.01
41	Interim payments	3,210,819			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	312,567			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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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				2,675,500		3,104,163	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	03/16/2017	29,333	12/31/2016	106,656	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	12/31/2016	139,355			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		-110,022		106,656	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)				2,565,478		3,210,819	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		274,257		312,567	6.01
	based on the cost report (1)		.02					6.02
7	Total Medicare program liability (see instructions)				2,839,735		3,523,386	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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				2,544,594			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	12/31/2016	200,454			3.51
		Provider	.52	03/16/2017	92,643			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		-293,097			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)				2,251,497			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		-285,310			6.02
7	Total Medicare program liability (see instructions)				1,966,187			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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	419	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,040	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	103	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,546	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	50,476,376	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	224,203	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & 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)		32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	1,609,066		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. 6 and 7, line 202 for Part B) (For CAH, see instructions)	447,875		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,093		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)	2,056,941		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	2,056,941		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	2,056,941		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	50,628		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)	2,006,313		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)	2,006,313		19
19.01	Sequestration adjustment (see instructions)	40,126		19.01
20	Interim payments	2,251,497		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-285,310		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §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	3,146,693	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	3,146,693	4
5	Primary payer payments	184	5
6	Total cost (see instructions)	3,156,893	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)	3,156,893	19
20	Deductibles (exclude professional component)	283,653	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,873,240	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	2,873,240	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,614	25
26	Adjusted reimbursable bad debts (see instructions)	24,449	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,614	27
28	Subtotal (sum of lines 24 and 26)	2,897,689	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,897,689	30
30.01	Sequestration adjustment (see instructions)	57,954	30.01
31	Interim payments	2,565,478	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	274,257	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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/IID [ ] 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	205,519		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	205,519		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	205,519		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)	205,519		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)	205,519		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)	205,519		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)	205,519		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	205,519		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)	205,519		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	205,519		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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	4,415,194				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	6,088,834				4
5	Other receivables	751,856				5
6	Allowances for uncollectible notes and accounts receivable	-1,317,819				6
7	Inventory	430,460				7
8	Prepaid expenses	508,936				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	10,877,461				11
	FIXED ASSETS					
12	Land	134,756				12
13	Land improvements	1,180,059				13
14	Accumulated depreciation	-833,611				14
15	Buildings	35,185,277				15
16	Accumulated depreciation	-10,382,976				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	2,749,340				19
20	Accumulated depreciation	-1,382,087				20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	10,639,988				23
24	Accumulated depreciation	-8,081,505				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)	29,209,241				30
	OTHER ASSETS					
31	Investments	2,472,975				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,427,093				34
35	Total other assets (sum of lines 31-34)	3,900,068				35
36	Total assets (sum of lines 11, 30 and 35)	43,986,770				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	1,107,116				37
38	Salaries, wages and fees payable	1,113,780				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	721,822				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	594,736				44
45	Total current liabilities (sum of lines 37 thru 44)	3,537,454				45
	LONG TERM LIABILITIES					
46	Mortgage payable	15,737,500				46
47	Notes payable	2,337,490				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	18,074,990				50
51	Total liabilities (sum of lines 45 and 50)	21,612,444				51
	CAPITAL ACCOUNTS					
52	General fund balance	22,374,326				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)	22,374,326				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	43,986,770				60

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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		24,668,087			1
2	Net income (loss) (from Worksheet G-3, line 29)		-2,305,324			2
3	Total (sum of line 1 and line 2)		22,362,763			3
4	Additions (credit adjustments) (specify)					4
5		11,563				5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)		11,563			10
11	Subtotal (line 3 plus line 10)		22,374,326			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)		22,374,326			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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	2,623,672		2,623,672	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	905,058		905,058	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)	3,528,730		3,528,730	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)	3,528,730		3,528,730	17
18	Ancillary services	6,476,884	36,676,621	43,153,505	18
19	Outpatient services	201	7,343,879	7,344,080	19
20	Rural Health Clinic (RHC)		1,478,715	1,478,715	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		651,251	651,251	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	10,005,815	46,150,466	56,156,281	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		29,686,132	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)		29,686,132	43

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	56,156,281	1
2	Less contractual allowances and discounts on patients' accounts	29,551,551	2
3	Net patient revenues (line 1 minus line 2)	26,604,730	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	29,686,132	4
5	Net income from service to patients (line 3 minus line 4)	-3,081,402	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	9,896	6
7	Income from investments	15,750	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	1,771	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	134,125	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	58,072	20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (PROPERTY TAX REVENUE)	257,244	24
24.01	Other (340(B) NET REVENUE)	232,470	24.01
24.02	Other (EHR MU REVENUE)	13,804	24.02
24.03	Other (GRANT REVENUE)	17,396	24.03
24.04	Other (OTHER MISCELLANEOUS REVENUE)	87,134	24.04
25	Total other income (sum of lines 6-24)	827,662	25
26	Total (line 5 plus line 25)	-2,253,740	26
27	Other expenses (LOSS ON DISPOSITION OF EQUIPMENT)	51,584	27
28	Total other expenses (sum of line 27 and subscripts)	51,584	28
29	Net income (or loss) for the period (line 26 minus line 28)	-2,305,324	29

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form **CMS-2552-10**	Period : From: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
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
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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	626,504	35,489	661,993	-217,432	444,561		444,561	1
2	Physician Assistant								2
3	Nurse Practitioner	371,974	21,071	393,045		393,045		393,045	3
4	Visiting Nurse								4
5	Other Nurse	215,722	12,220	227,942		227,942		227,942	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)	1,214,200	68,780	1,282,980	-217,432	1,065,548		1,065,548	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		17,774	17,774		17,774		17,774	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)		17,774	17,774		17,774		17,774	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,214,200	86,554	1,300,754	-217,432	1,083,322		1,083,322	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
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	124,583	235,619	360,202	-29,063	331,139		331,139	30
31	Total Facility Overhead (sum of lines 29 and 30)	124,583	235,619	360,202	-29,063	331,139		331,139	31
32	Total faciilty costs (sum of lines 22, 28 and 31)	1,338,783	322,173	1,660,956	-246,495	1,414,461		1,414,461	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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	1.06	2,570	4,200	4,452		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	3.33	6,508	2,100	6,993		3
4	Subtotal (sum of lines 1 through 3)	4.39	9,078		11,445	11,445	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)	4.39	9,078			11,445	8
9	Physician Services Under Agreements		2,271			2,271	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)	1,083,322	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)	1,083,322	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)	331,139	14
15	Parent provider overhead allocated to facility (see instructions)	797,708	15
16	Total overhead (sum of lines 14 and 15)	1,128,847	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,128,847	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,128,847	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	2,212,169	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	2,212,169	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)	2,212,169	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	11,445	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	2,271	5
6	Total adjusted visits (line 4 plus line 5)	13,716	6
7	Adjusted cost per visit (line 3 divided by line 6)	161.28	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)	161.28	161.28	161.28	9
	CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from contractor records)		1,965		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		316,915		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)		316,915		16
16.01	Total program charges (see instructions)(from contractor's records)		265,347		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)		223,090		16.04
16.05	Total program cost (see instructions)		223,090		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		38,053		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		45,459		19
20	Net Medicare cost excluding vaccines (see instructions)		223,090		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)		223,090		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)		223,090		26
26.01	Sequestration adjustment (see instructions)		4,462		26.01
27	Interim payments		215,638		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		2,990		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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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)	1,065,548	1,065,548	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)	1,083,322	1,083,322	6
7	Total overhead (from Wkst. M-2, line 16)	1,128,847	1,128,847	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: 04/01/2016 To: 03/31/2017	Run Date: 08/26/2017 Run Time: 10:07 Version: 2017.01 (05/18/2017)

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				178,167	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	12/31/2016	27,396	3.01
	amount based on subsequent revision of the interim		.02	03/16/2017	10,075	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		37,471	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				215,638	
	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		2,990	6.01
	based on the cost report (1)		.02			6.02
7	Total Medicare program liability (see instructions)				218,628	
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.