

SALEM TOWNSHIP HOSPITAL

SALEM, ILLINOIS

MEDICARE ANALYSIS

FOR THE YEAR ENDED MARCH 31, 2014

National Government Services, Inc.
Cost Reporting Unit
PO Box 6474
Indianapolis, IN 46206-6474

Dear Sir or Madam:

The amended cost report of Salem Township Hospital for the fiscal year ended March 31, 2014 includes one Level 2000 Error.

20300 Worksheet C, Part I, Line 72, Col 11 should not be more than 100% or less than .1%.

The Hospital's implantable devices cost to charge ratio was 1.089475 as the number of implants in 2014 did not generate enough revenue to cover the expense of the supplies including allocated overhead. As a rural hospital Salem Township Hospital qualifies for cost reimbursement for these services. The reimbursement program is designed for rural hospitals with lower surgery volumes.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:17 Version: 2014.03
--	--------------------------------	--	---

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. <input checked="" type="checkbox"/> ELECTRONICALLY FILED COST REPORT	DATE: 08/25/2014	TIME: 09:17
	2. <input type="checkbox"/> MANUALLY SUBMITTED COST REPORT		
	3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT		
	4. <input checked="" type="checkbox"/> MEDICARE UTILIZATION. ENTER 'F' FOR FULL OR 'L' FOR LOW.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR 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 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 04/01/2013 AND ENDING 03/31/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR Encryption: 08/25/2014 09:17
n4ksID3o76U1YjIJM5yWaKNSVz:1j0
vCFSW0N&xMBcYNqIDh7yklhw.Jb.Rl
T6570R0h5S0MgVFX

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

TITLE

DATE

PI Encryption: 08/25/2014 09:17
qMVCHxez.CdbZesvD5o1SU70JmwIM0
MWIra0E2GKn7n98ZdfjsgWPWiujsl
SHA104Iskf0RYF9u

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		-108,099	-979,273	31,546	75,011	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-49,623				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			21,121			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-157,722	-958,152	31,546	75,011	200

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 673 HOURS PER RESPONSE, INCLUDING THE TIME TO REVIEW INSTRUCTIONS, SEARCH EXISTING RESOURCES, GATHER THE DATA NEEDED, AND COMPLETE AND REVIEW THE INFORMATION COLLECTION. IF YOU HAVE ANY COMMENTS CONCERNING THE ACCURACY OF THE TIME ESTIMATE(S) OR SUGGESTIONS FOR IMPROVING THIS FORM, PLEASE WRITE TO: CMS, 7500 SECURITY BOULEVARD, ATTN: PRA REPORT CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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:										
							Payment System (P, T, O, or N)			
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	SALEM TOWNSHIP HOSPITAL	14-1345	16460	1	07/01/1966	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	SALEM S/B SNF	14-Z345	16460		12/17/1986	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA	SALEM HOME HEALTH AGENCY	14-7429	16460		08/01/1985	N	P	N	12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	PHOTOS RURAL HEALTH CLINIC	14-3413	16460		07/29/1996	N	O	N	15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19
20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2013	To: 03 / 31 / 2014							20
21	Type of control (see instructions)	12								21
Inpatient PPS Information										
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
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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									24
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.									25
26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.				2					26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.				2					27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.									35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:			36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.									37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:		Ending:			38
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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
		1	2	3	
Prospective Payment System (PPS)-Capital		N	N	N	45
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 Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48
Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N	N		57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	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 osteopathic 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 received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (see instructions)	N			63

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					64
Enter in lines 65-65.49 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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					66
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 Facility PPS			1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.		N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.					71
Inpatient Rehabilitation Facility PPS			1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.		N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.					76
Long Term Care Hospital PPS						
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.			N		80
TEFRA Providers						
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.			N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.					86

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Title V and XIX Services		V	XIX			
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90		
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91		
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92		
93	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93		
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94		
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95		
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96		
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97		
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)	N		106		
107	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.	N		107		
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108		
		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
Miscellaneous Cost Reporting Information						
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98'	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:	177,391			118.01	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02	
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.		N	N	120	
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.		Y		121	
Transplant Center Information						
125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.		N		125	
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126	
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127	
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128	
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129	
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				130	
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				131	
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				132	
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				133	
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.				134	

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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 Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	N		145		
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, section 4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146		
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147		
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148		
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)						
		Title XVIII				
		Part A	Part B	Title V		
				Title XIX		
				3		
155	Hospital	N	N	2	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			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.					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	34,038				168
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)					169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2012	09/30/2013			170

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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	
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	COLUMN 1: WERE THE FINANCIAL STATEMENTS PREPARED BY A CERTIFIED PUBLIC ACCOUNTANT? COLUMN 2: IF YES, ENTER 'A' FOR AUDITED, 'C' FOR COMPILED, OR 'R' FOR REVIEWED. SUBMIT COMPLETE COPY OR ENTER DATE AVAILABLE IN COLUMN 3. (see instructions). IF NO, SEE INSTRUCTIONS.	Y	A	4	
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y		5	
APPROVED EDUCATIONAL ACTIVITIES		Y/N	Y/N		
		1	2		
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N		6	
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N		7	
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N		8	
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N		9	
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N		10	
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N		11	
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
		1	2	3	4
PS&R REPORT DATA					
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	07/03/2014	Y	07/03/2014
18	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR ADDITIONAL CLAIMS THAT HAVE BEEN BILLED BUT ARE NOT INCLUDED ON THE PS&R REPORT USED TO FILE THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	18
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS: RECLASS OF MED SUPPLIES, CT, AND MR	Y		Y	20
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	21

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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 COSTS			
22	HAVE ASSETS BEEN RELIEFED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.	Y	22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N	27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	Y	28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.	Y	29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.	N	31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.	N	32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.	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
HOME OFFICE COSTS		Y/N	DATE
		1	2
36	WERE 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 REORT PREPARER INFORMATION			
41	FIRST NAME: MARK	LAST NAME: DALLAS	TITLE: PARTNER
42	EMPLOYER: KERBER, ECK & BRAECKEL, LLP		42
43	PHONE NUMBER: 618-529-1040	E-MAIL ADDRESS: MDALLAS@KEBCPA.COM	43

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	WKST A LINE NO.	NO. OF BEDS	BED DAYS AVAILABLE	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						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	64,872.00		1,968	71	2,703	1
2	HMO AND OTHER (see instructions)						20			2
3	HMO IPF SUBPROVIDER									3
4	HMO IRF SUBPROVIDER									4
5	HOSPITAL ADULTS & PEDS. SWING BED SNF						496		496	5
6	HOSPITAL ADULTS & PEDS. SWING BED NF								74	6
7	TOTAL ADULTS & PEDS. (exclude observation beds)(see instructions)		25	9,125	64,872.00		2,464	71	3,273	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	64,872.00		2,464	71	3,273	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					899		7,144	26
27	TOTAL (sum of lines 14-26)		25							27
28	OBSERVATION BED DAYS								386	28
29	AMBULANCE TRIPS									29
30	EMPLOYEE DISCOUNT DAYS (see instructions)									30
31	EMPLOYEE DISCOUNT DAYS-IRF									31
32	LABOR & DELIVERY DAYS (see instructions)									32
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)									32.01
33	LTCH NON-COVERED DAYS									33

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	COMPONENT	FULL TIME EQUIVALENTS			DISCHARGES			TOTAL ALL PATIENTS	
		TOTAL INTERNS & RESIDENTS	EMPLOYEES ON PAYROLL	NONPAID WORKERS	TITLE V	TITLE XVIII	TITLE XIX		
		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)					495	71	737	1
2	HMO AND OTHER (see instructions)					5			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)		176.61			495	71	737	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		9.44						26
27	TOTAL (sum of lines 14-26)		186.05						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200						1
2							2
3							3
4							4
4.01							4.01
5							5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10							10
OTHER WAGES & RELATED COSTS							
11							11
12							12
13							13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17							17
18							18
19							19
20							20
21							21
22							22
22.01							22.01
23							23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
37							37
38							38
39							39
40							40
41							41
42							42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)						1
2	EXCLUDED AREA SALARIES (see instructions)						2
3	SUBTOTAL SALARIES (line 1 minus line 2)						3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)						4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)						5
6	TOTAL (sum of lines 3 through 5)						6
7	TOTAL OVERHEAD COST (see instructions)						7

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3
PART IV

PART IV - WAGE RELATED COST

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN		6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)		8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN		10
11	LIFE INSURANCE (If employee is owner or beneficiary)		11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)		13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE		15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY		17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE		19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT		23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)		24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
----	------------------------------------	--	----

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	Supporting Exhibit for Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---	--	---

WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB- UTION(S)
11			11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

HOSPITAL CONTRACT LABOR AND BENEFIT COST

WORKSHEET S-3
PART V

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 14-7429

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

	DESCRIPTION	TITLE V	TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	5	
1	HOME HEALTH AIDE HOURS						1
2	UNDUPLICATED CENSUS COUNT (see instructions)						2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK	NUMBER OF EMPLOYEES (Full Time Equivalent)			
		STAFF	CONTRACT	TOTAL	
		1	2	3	
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)				4
5	OTHER ADMINISTRATIVE PERSONNEL				5
6	DIRECT NURSING SERVICE				6
7	NURSING SUPERVISOR				7
8	PHYSICAL THERAPY SERVICE				8
9	PHYSICAL THERAPY SUPERVISOR				9
10	OCCUPATIONAL THERAPY SERVICE				10
11	OCCUPATIONAL THERAPY SUPERVISOR				11
12	SPEECH PATHOLOGY SERVICE				12
13	SPEECH PATHOLOGY SUPERVISOR				13
14	MEDICAL SOCIAL SERVICE				14
15	MEDICAL SOCIAL SERVICE SUPERVISOR				15
16	HOME HEALTH AIDE				16
17	HOME HEALTH AIDE SUPERVISOR				17
18	OTHER (SPECIFY)				18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.	1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).	16460	20

PPS ACTIVITY

		FULL EPISODES				TOTAL (columns 1 through 4)	
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES		
		1	2	3	4	5	
21	SKILLED NURSING VISITS						21
22	SKILLED NURSING VISIT CHARGES						22
23	PHYSICAL THERAPY VISITS						23
24	PHYSICAL THERAPY VISIT CHARGES						24
25	OCCUPATIONAL THERAPY VISITS						25
26	OCCUPATIONAL THERAPY VISIT CHARGES						26
27	SPEECH PATHOLOGY VISITS						27
28	SPEECH PATHOLOGY VISIT CHARGES						28
29	MEDICAL SOCIAL SERVICE VISITS						29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES						30
31	HOME HEALTH AIDE VISITS						31
32	HOME HEALTH AIDE VISIT CHARGES						32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)						33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)						35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)						36
37	TOTAL NUMBER OF OUTLIER EPISODES						37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES						38

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

	GROUP 1	SNF DAYS 2	SWING BED SNF DAYS 3	TOTAL (sum of col. 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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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	
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

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 CATEGORY. ENTER IN COLUMN 2 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 7, COLUMN 3. IN COLUMN 3, ENTER 'Y' OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (see instructions)

		EXPENSES	PERCENTAGE	ASSOCIATED 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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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

COMPONENT CCN: 14-3413

WORKSHEET S-8

CHECK [XX] RHC [] FQHC
APPLICABLE BOX:

CLINIC ADDRESS AND IDENTIFICATION:

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

SOURCE OF FEDERAL FUNDS:

		GRANT AWARD	DATE	
		1	2	
4	COMMUNITY HEALTH CENTER (Section 330(d), PHS Act)			4
5	MIGRANT HEALTH CENTER (Section 329(d), PHS Act)			5
6	HEALTH SERVICES FOR HOMELESS (Section 340(d), PHS Act)			6
7	APPALACHIAN REGIONAL COMMISSION			7
8	LOOK-ALIKES			8
9	OTHER			9

10	DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, INDICATE THE NUMBER OF OTHER OPERATIONS IN COLUMN 2.	1 N	2	10
----	--	--------	---	----

FACILITY HOURS OF OPERATIONS(1)

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

12	HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD?	1 N	2	12
13	IS THIS A CONSOLIDATED COST REPORT AS DEFINED IN CMS PUB. 27, SECTION 508(D)?	N		13
14	PROVIDER NAME: CCN NUMBER:			14

		Y/N	V	XVIII	XIX	TOTAL VISITS	
		1	2	3	4	5	
15	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED IN COLUMN 1. IF YES, ENTER IN 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS AND RESIDENTS FOR TITLES V, XVIII, AND XIX, AS APPLICABLE. (see instructions)	N					15

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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)	0.409352	1
---	--	----------	---

MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	1,302,527	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	1,191,874	5
6	MEDICAID CHARGES	6,043,436	6
7	MEDICAID COST (line 1 times line 6)	2,473,893	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.		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 AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)		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	291,451	376,272	667,723	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	119,306	154,028	273,334	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	32,672	70,646	103,318	22
23	COST OF CHARITY CARE (line 21 minus line 22)	86,634	83,382	170,016	23

24	DOES THE AMOUNT IN LINE 20, COLUMN 2 INCLUDE CHARGES FOR PATIENT DAYS BEYOND A LENGTH OF STAY LIMIT IMPOSED ON PATIENTS COVERED BY MEDICAID OR OTHER INDIGENT CARE PROGRAM?	N	24
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	1,241,349	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	491,809	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	749,540	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	306,826	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	476,842	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	476,842	31

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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		1,153,861	1,153,861	487,151	1,641,012		1,641,012	1
2	00200	CAP REL COSTS-MVBLE EQUIP		889,599	889,599	791,127	1,680,726	-342,684	1,338,042	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	110,710	1,890,662	2,001,372		2,001,372	-63,783	1,937,589	4
5.01	00592	ADMINISTRATIVE & ACCOUNTING	609,368	1,213,233	1,822,601	-496,534	1,326,067	-272,256	1,053,811	5.01
5.02	00591	BUSINESS SERVICES	589,094	628,057	1,217,151		1,217,151	-25,834	1,191,317	5.02
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	229,172	595,226	824,398	-4,963	819,435		819,435	7
8	00800	LAUNDRY & LINEN SERVICE	27,576	20,321	47,897		47,897		47,897	8
9	00900	HOUSEKEEPING	117,443	76,801	194,244		194,244		194,244	9
10	01000	DIETARY	259,291	394,886	654,177	-474,720	179,457	-29,415	150,042	10
11	01100	CAFETERIA				473,763	473,763	-110,172	363,591	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	84,346	18,569	102,915		102,915		102,915	13
14	01400	CENTRAL SERVICES & SUPPLY								14
14.01	01401	PURCHASING	90,205	16,980	107,185		107,185		107,185	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	15,315	533,113	548,428	-548,428				14.02
15	01500	PHARMACY	44,826	1,257,859	1,302,685	-2,500	1,300,185	-454	1,299,731	15
16	01600	MEDICAL RECORDS & LIBRARY	155,506	160,457	315,963	-1,841	314,122		314,122	16
17	01700	SOCIAL SERVICE	54,944	9,051	63,995		63,995		63,995	17
19	01900	NONPHYSICIAN ANESTHETISTS				534,000	534,000	-534,000		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 SERV COST CENTERS								
30	03000	ADULTS & PEDIATRICS	1,856,214	466,055	2,322,269	-4,098	2,318,171	-397,840	1,920,331	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	OPERATING ROOM	615,824	481,639	1,097,463	-86,998	1,010,465	-86,500	923,965	50
53	05300	ANESTHESIOLOGY		566,356	566,356	-566,356				53
54	05400	RADIOLOGY-DIAGNOSTIC	562,133	424,186	986,319	-48,635	937,684		937,684	54
57	05700	CT SCAN	77,714	135,469	213,183		213,183		213,183	57
58	05800	MRI	83,595	470,598	554,193	-454,874	99,319		99,319	58
60	06000	LABORATORY	592,395	1,177,255	1,769,650	-245,561	1,524,089		1,524,089	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	304,122	192,824	496,946	-10,044	486,902	-52,172	434,730	65
66	06600	PHYSICAL THERAPY		812,380	812,380	-770	811,610		811,610	66
67	06700	OCCUPATIONAL THERAPY								67
68	06800	SPEECH PATHOLOGY								68
69	06900	ELECTROCARDIOLOGY	67,514	24,686	92,200		92,200	-44,824	47,376	69
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				548,428	548,428		548,428	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS		321,502	321,502		321,502		321,502	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	491,684	104,284	595,968	69,561	665,529		665,529	88
90	09000	CLINIC	141,428	25,879	167,307	-5,225	162,082		162,082	90
90.01	09001	SALEM MEDICAL CLINIC								90.01
91	09100	EMERGENCY	901,797	2,046,259	2,948,056	-93,079	2,854,977	-1,139,784	1,715,193	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	8,082,216	16,108,047	24,190,263	-140,596	24,049,667	-3,099,718	20,949,949	118
		NONREIMBURSABLE COST CENTERS								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48,065	60,144	108,209		108,209		108,209	190
192	19200	PHYSICIANS' PRIVATE OFFICES	44,846	5,103	49,949		49,949		49,949	192
192.01	19201	TEMPORARILY IDLE SPACE								192.01
192.02	19202	STH FAM HLTH CRT	393,588	143,757	537,345	140,596	677,941		677,941	192.02
200		TOTAL (sum of lines 118-199)	8,568,715	16,317,051	24,885,766		24,885,766	-3,099,718	21,786,048	200

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
			COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS CAFETERIA COST	A	CAFETERIA	11	187,782	285,981	1
500	TOTAL RECLASSIFICATIONS				187,782	285,981	500
	CODE LETTER - A						
1	TO RECLASSIFY SUPPLY COST	B	MEDICAL SUPPLIES CHARGED TO P	71	15,315	533,113	1
500	TOTAL RECLASSIFICATIONS				15,315	533,113	500
	CODE LETTER - B						
1	TO RECLASS RENTALS	C	CAP REL COSTS-MVBLE EQUIP	2		791,127	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
500	TOTAL RECLASSIFICATIONS					791,127	500
	CODE LETTER - C						
1	TO RECLASS CRNA COST	D	NONPHYSICIAN ANESTHETISTS	19		534,000	1
500	TOTAL RECLASSIFICATIONS					534,000	500
	CODE LETTER - D						
1	TO RECLASS REMAINING ANESTHESIA SUPP	E	OPERATING ROOM	50		32,356	1
500	TOTAL RECLASSIFICATIONS					32,356	500
	CODE LETTER - E						
1	TO RECLASS INTEREST EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		396,743	1
500	TOTAL RECLASSIFICATIONS					396,743	500
	CODE LETTER - F						
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G	RURAL HEALTH CLINIC	88		74,119	1
500	TOTAL RECLASSIFICATIONS					74,119	500
	CODE LETTER - G						
1	TO RECLASS OTHER CAPITAL COSTS	H	CAP REL COSTS-BLDG & FIXT	1		90,408	1
500	TOTAL RECLASSIFICATIONS					90,408	500
	CODE LETTER - H						
1	RECLASS PHYSICIAN ADMIN TIME	I	ADULTS & PEDIATRICS	30		22,308	1
2							2
500	TOTAL RECLASSIFICATIONS					22,308	500
	CODE LETTER - I						
1	RECLASS THE REF LAB TO FHCC	J	STH FAM HLTH CRT	192.02		160,596	1
500	TOTAL RECLASSIFICATIONS					160,596	500
	CODE LETTER - J						
	GRAND TOTAL (INCREASES)					203,097	2,920,751

(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.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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	187,782	285,981	1	
500	TOTAL RECLASSIFICATIONS				187,782	285,981	500	
	CODE LETTER - A							
1	TO RECLASSIFY SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	14.02	15,315	533,113	1	
500	TOTAL RECLASSIFICATIONS				15,315	533,113	500	
	CODE LETTER - B							
1	TO RECLASS RENTALS	C	ADMINISTRATIVE & ACCOUNTING	5.01		9,383	10	
2			OPERATION OF PLANT	7		4,963	2	
3			DIETARY	10		957	3	
4			MEDICAL RECORDS & LIBRARY	16		1,841	4	
5			ADULTS & PEDIATRICS	30		26,406	5	
6			OPERATING ROOM	50		119,354	6	
7			RADIOLOGY-DIAGNOSTIC	54		48,635	7	
8			LABORATORY	60		84,965	8	
9			RESPIRATORY THERAPY	65		10,044	9	
10			PHYSICAL THERAPY	66		770	10	
11			CLINIC	90		5,225	11	
12			RURAL HEALTH CLINIC	88		2,250	12	
13			MRI	58		454,874	13	
14			PHARMACY	15		2,500	14	
15			EMERGENCY	91		18,960	15	
500	TOTAL RECLASSIFICATIONS					791,127	500	
	CODE LETTER - C							
1	TO RECLASS CRNA COST	D	ANESTHESIOLOGY	53		534,000	1	
500	TOTAL RECLASSIFICATIONS					534,000	500	
	CODE LETTER - D							
1	TO RECLASS REMAINING ANESTHESIA SUPP	E	ANESTHESIOLOGY	53		32,356	1	
500	TOTAL RECLASSIFICATIONS					32,356	500	
	CODE LETTER - E							
1	TO RECLASS INTEREST EXPENSE	F	ADMINISTRATIVE & ACCOUNTING	5.01		396,743	14	
500	TOTAL RECLASSIFICATIONS					396,743	500	
	CODE LETTER - F							
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G	EMERGENCY	91		74,119	1	
500	TOTAL RECLASSIFICATIONS					74,119	500	
	CODE LETTER - G							
1	TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	5.01		90,408	14	
500	TOTAL RECLASSIFICATIONS					90,408	500	
	CODE LETTER - H							
1	RECLASS PHYSICIAN ADMIN TIME	I	STH FAM HLTH CRT	192.02		20,000	1	
2			RURAL HEALTH CLINIC	88		2,308	2	
500	TOTAL RECLASSIFICATIONS					22,308	500	
	CODE LETTER - I							
1	RECLASS THE REF LAB TO FHCC	J	LABORATORY	60		160,596	1	
500	TOTAL RECLASSIFICATIONS					160,596	500	
	CODE LETTER - J							
	GRAND TOTAL (DECREASES)				203,097	2,920,751		

(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.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE	FULLY DEPRECIATED ASSETS	
			PURCHASES	DONATION	TOTAL				
			1	2	3				
1	LAND	99,381				99,381		1	
2	LAND IMPROVEMENTS	1,021,091	119,108		119,108	1,140,199		2	
3	BUILDINGS AND FIXTURES	24,792,209	6,887,534		6,887,534	676,198	31,003,545	3	
4	BUILDING IMPROVEMENTS							4	
5	FIXED EQUIPMENT	1,927,798	29,504		29,504	1,957,302		5	
6	MOVABLE EQUIPMENT	8,668,952	495,860		495,860	228,498	8,936,314	6	
7	HIT DESIGNATED ASSETS	1,079,269	34,038		34,038	1,113,307		7	
8	SUBTOTAL (sum of lines 1-7)	37,588,700	7,566,044		7,566,044	904,696	44,250,048	8	
9	RECONCILING ITEMS							9	
10	TOTAL (line 7 minus line 9)	37,588,700	7,566,044		7,566,044	904,696	44,250,048	10	

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

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
		9	10	11	12	13	14	15		
*										
1	CAP REL COSTS-BLDG & FIXT	1,153,861							1,153,861	1
2	CAP REL COSTS-MVBLE EQUIP	889,599							889,599	2
3	TOTAL (sum of lines 1-2)	2,043,460							2,043,460	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

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
		9	10	11	12	13	14	15	16	
*										
1	CAP REL COSTS-BLDG & FI				0.000000					1
2	CAP REL COSTS-MVBLE EQU				0.000000					2
3	TOTAL (sum of lines 1-2)				0.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
		9	10	11	12	13	14	15		
*										
1	CAP REL COSTS-BLDG & FIXT	1,153,861					487,151	1,641,012	1	
2	CAP REL COSTS-MVBLE EQUIP	889,599	791,127				-342,684	1,338,042	2	
3	TOTAL (sum of lines 1-2)	2,043,460	791,127				144,467	2,979,054	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.)

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF. 5
				COST CENTER	LINE#	
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)	B	-2,401	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	-1,614	ADMINISTRATIVE & ACCOUNTING	5.01	7
8	TELEVISION AND RADIO SERVICE (chapter 21)	A	-1,852	ADMINISTRATIVE & ACCOUNTING	5.01	8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-1,721,120			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	-110,172	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-454	PHARMACY	15	17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS					18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES					20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT			CAP REL COSTS-MVBLE EQUIP	2	27
28	NON-PHYSICIAN ANESTHETIST		-534,000	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 AND	B	-334,010	CAP REL COSTS-MVBLE EQUIP	2	14
33						33
34	DIETARY REVENUE	B	-29,415	DIETARY	10	34
35	BUS OFFICE COSTS ASSOC W/ PHYS CHG	A	-25,834	BUSINESS SERVICES	5.02	35
36	TELEPHONE	A	-184	ADMINISTRATIVE & ACCOUNTING	5.01	14
37	PHYSICIAN RECRUITMENT	A	-82,236	ADMINISTRATIVE & ACCOUNTING	5.01	37
38	OTHER REVENUE	B	-97	ADMINISTRATIVE & ACCOUNTING	5.01	38
39	LOBBYING PORTION OF DUES	A	-15,455	ADMINISTRATIVE & ACCOUNTING	5.01	39
40	MARKETING	A	-63,783	EMPLOYEE BENEFITS DEPARTMENT	4	40
41	OTHER REVENUE	B	-527	ADMINISTRATIVE & ACCOUNTING	5.01	41
42	SPOUSE MEAL COST	A	-760	ADMINISTRATIVE & ACCOUNTING	5.01	42
43	GOODWILL AMORTIZATION- PHY. CLINIC	A	-167,130	ADMINISTRATIVE & ACCOUNTING	5.01	43
44						44
45						45
46						46
47	IMPAIRED ASSETS	A	-8,674	CAP REL COSTS-MVBLE EQUIP	2	14
48						48
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,099,718			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 subscripits thereof.

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE		
				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:

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUN- ERATION	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
	1	50 OPERATING ROOM OR	86,500	86,500						1
	2	60 LABORATORY LABORATORY	81,278		81,278					2
	3	65 RESPIRATORY THERAPY RESPIRATORY THE	370	370						3
	4	65 RESPIRATORY THERAPY RESPIRATORY THE	51,582	51,582						4
	5	69 ELECTROCARDIOLOGY ELECTROCARDIOLO	16,266	16,266						5
	6	91 EMERGENCY EMERGENCY	1,835,992	1,139,784	696,208					6
	7	53 ANESTHESIOLOGY ANESTHESIOLOGY	28,000		28,000					7
	8	30 ADULTS & PEDIATRICS HOSPITALIST	212,888	192,888	20,000					8
	9	65 RESPIRATORY THERAPY RESPIRATORY THE	220	220						9
	10	69 ELECTROCARDIOLOGY ELECTROCARDIOLO	28,558	28,558						10
	11	30 ADULTS & PEDIATRICS HOSPITALIST	204,952	204,952						11
	200	TOTAL	2,546,606	1,721,120	825,486					200

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	50	OPERATING ROOM OR							86,500	1
2	60	LABORATORY LABORATORY								2
3	65	RESPIRATORY THERAPY RESPIRATORY THE							370	3
4	65	RESPIRATORY THERAPY RESPIRATORY THE							51,582	4
5	69	ELECTROCARDIOLOGY ELECTROCARDIOLO							16,266	5
6	91	EMERGENCY EMERGENCY							1,139,784	6
7	53	ANESTHESIOLOGY ANESTHESIOLOGY								7
8	30	ADULTS & PEDIATRICS HOSPITALIST							192,888	8
9	65	RESPIRATORY THERAPY RESPIRATORY THE							220	9
10	69	ELECTROCARDIOLOGY ELECTROCARDIOLO							28,558	10
11	30	ADULTS & PEDIATRICS HOSPITALIST							204,952	11
200		TOTAL							1,721,120	200

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

CHECK APPLICABLE BOX: [XX] OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					24	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					360	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.60	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		1,247.00				9
10	AHSEA (see instructions)		71.97				10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.99	35.99				11
12	NUMBER OF TRAVEL HOURS (PROVIDER SITE) (see instructions)						12
12.01	NUMBER OF TRAVEL HOURS (OFFSITE) (see instructions)						12.01
13	NUMBER OF MILES DRIVEN (PROVIDER SITE) (see instructions)						13
13.01	NUMBER OF MILES DRIVEN (OFFSITE) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	SUPERVISORS (column 1, line 9 times column 1, line 10)						14
15	THERAPISTS (column 2, line 9 times column 2, line 10)					89,747	15
16	ASSISTANTS (column 3, line 9 times column 3, line 10)						16
17	SUBTOTAL ALLOWANCE AMOUNT (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					89,747	17
18	AIDES (column 4, line 9 times column 4, line 10)						18
19	TRAINEES (column 5, line 9 times column 5, line 10)						19
20	TOTAL ALLOWANCE AMOUNT (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					89,747	20
	IF THE SUM OF COLUMNS 1 AND 2 FOR RESPIRATORY THERAPY OR COLUMNS 1 THROUGH 3 FOR PHYSICAL THERAPY, SPEECH PATHOLOGY OR OCCUPATIONAL THERAPY, LINE 9 IS GREATER THAN LINE 2, MAKE NO ENTRIES ON LINES 21 AND 22 AND ENTER ON LINE 23 THE AMOUNT FROM LINE 20. OTHERWISE COMPLETE LINES 21 THROUGH 23.						
21	WEIGHTED AVERAGE RATE EXCLUDING AIDES AND TRAINEES (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)						21
22	WEIGHTED ALLOWANCE EXCLUDING AIDES AND TRAINEES (line 2 times line 21)						22
23	TOTAL SALARY EQUIVALENCY (see instructions)					89,747	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	OPTIONAL 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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 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 in column 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 OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)		89,747	57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)			58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)			59
60	OVERTIME ALLOWANCE (from column 5, line 56)			60
61	EQUIPMENT COST (see instructions)			61
62	SUPPLIES (see instructions)			62
63	TOTAL ALLOWANCE (sum of lines 57-62)		89,747	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		59,806	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)			65

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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 I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					24	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					360	2
3	NUMBER OF UNDUPLICATED DAYS IN WHICH SUPERVISOR OR THERAPIST WAS ON PROVIDER SITE (see instructions)						3
4	NUMBER OF UNDUPLICATED DAYS IN WHICH THERAPY ASSISTANT WAS ON PROVIDER SITE BUT NEITHER SUPERVISOR NOR THERAPIST WAS ON PROVIDER SITE (see instructions)						4
5	NUMBER OF UNDUPLICATED OFFSITE VISITS - SUPERVISORS OR THERAPISTS (see instructions)						5
6	NUMBER OF UNDUPLICATED OFFSITE VISITS - THERAPY ASSISTANTS (INCLUDE ONLY VISITS MADE BY THERAPY ASSISTANT AND ON WHICH SUPERVISOR AND/OR THERAPIST WAS NOT PRESENT DURING THE VISITS(S)) (see instructions)						6
7	STANDARD TRAVEL EXPENSE RATE					5.60	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		3,680.20		4,184.50		9
10	AHSEA (see instructions)		75.94		18.90		10
11	STANDARD TRAVEL ALLOWANCE (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.97	37.97				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)					279,474	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)					279,474	17
18	AIDES (column 4, line 9 times column 4, line 10)					79,087	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)					358,561	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)					358,561	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	OPTIONAL 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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 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 in column 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 OVERTIME 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)					358,561	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)					358,561	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)					305,163	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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 I - GENERAL INFORMATION

1	TOTAL NUMBER OF WEEKS WORKED (EXCLUDING AIDES) (see instructions)					22	1
2	LINE 1 MULTIPLIED BY 15 HOURS PER WEEK					330	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					5.60	7
8	OPTIONAL TRAVEL EXPENSE RATE						8
		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
9	TOTAL HOURS WORKED		359.00				9
10	AHSEA (see instructions)		69.16				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)	34.58	34.58				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)					24,828	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)					24,828	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)					24,828	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)					24,828	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	OPTIONAL 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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 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 in column 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 OVERTIME 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)		24,828	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)		24,828	63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)		17,189	64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)			65

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRA TIVE & ACC OUNTING	
		0	1	2	4	4A	5.01	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	1,641,012	1,641,012					1
2	CAP REL COSTS-MVBLE EQUIP	1,338,042		1,338,042				2
4	EMPLOYEE BENEFITS DEPARTMENT	1,937,589	8,649	1,154	1,947,392			4
5.01	ADMINISTRATIVE & ACCOUNTING	1,053,811	359,736	16,905	140,302	1,570,754	1,570,754	5.01
5.02	BUSINESS SERVICES	1,191,317	96,525	311,783	135,634	1,735,259	134,831	5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	819,435	189,246	22,912	52,765	1,084,358	84,256	7
8	LAUNDRY & LINEN SERVICE	47,897	13,496	57	6,349	67,799	5,268	8
9	HOUSEKEEPING	194,244	11,763	26	27,040	233,073	18,110	9
10	DIETARY	150,042	43,539	2,341	16,464	212,386	16,503	10
11	CAFETERIA	363,591			43,235	406,826	31,611	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	102,915	8,711	605	19,420	131,651	10,229	13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING	107,185	20,550	371	20,769	148,875	11,568	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	PHARMACY	1,299,731	10,781	2,010	10,321	1,322,843	102,786	15
16	MEDICAL RECORDS & LIBRARY	314,122	27,543	22,378	35,804	399,847	31,069	16
17	SOCIAL SERVICE	63,995			12,650	76,645	5,955	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	1,920,331	84,149	59,052	427,383	2,490,915	193,551	30
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	923,965	92,384	169,799	141,789	1,327,937	103,182	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	937,684	44,413	179,728	129,427	1,291,252	100,332	54
57	CT SCAN	213,183	7,361	2,797	17,893	241,234	18,744	57
58	MRI	99,319		360,899	19,247	479,465	37,255	58
60	LABORATORY	1,524,089	94,056	93,979	136,394	1,848,518	143,632	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	434,730	49,704	17,791	70,022	572,247	44,464	65
66	PHYSICAL THERAPY	811,610	86,234	4,348		902,192	70,101	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	47,376		8,685	15,545	71,606	5,564	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	548,428	14,723	328	3,526	567,005	44,057	71
72	IMPL. DEV. CHARGED TO PATIENTS	321,502				321,502	24,981	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	665,529	31,393	2,802	113,206	812,930	63,165	88
90	CLINIC	162,082	17,851	6,852	32,563	219,348	17,044	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	1,715,193	50,241	35,552	207,632	2,008,618	156,072	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	20,949,949	1,363,048	1,323,154	1,835,380	20,545,085	1,474,330	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	108,209	15,949	4,153	11,067	139,378	10,830	190
192	PHYSICIANS' PRIVATE OFFICES	49,949	4,125	3,789	10,325	68,188	5,298	192
192.01	TEMPORARILY IDLE SPACE		202,312			202,312	15,720	192.01
192.02	STH FAM HLTH CRT	677,941	55,578	6,946	90,620	831,085	64,576	192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	21,786,048	1,641,012	1,338,042	1,947,392	21,786,048	1,570,754	202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		5.02	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES	1,870,090						5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		1,168,614					7
8	LAUNDRY & LINEN SERVICE		15,981	89,048				8
9	HOUSEKEEPING		13,929	5,255	270,367			9
10	DIETARY		51,558	555	7,668	288,670		10
11	CAFETERIA						438,437	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		10,315				5,302	13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING		24,335				6,826	14.01
14.02	CENTRAL SERVICES & SUPPLY					5,396		14.02
15	PHARMACY		12,767			2,272	5,136	15
16	MEDICAL RECORDS & LIBRARY		32,616			3,692	15,540	16
17	SOCIAL SERVICE						3,380	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	138,209	99,647	46,374	102,523	288,670	119,350	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	123,173	109,399	9,075	26,412		36,879	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	178,528	52,593	11,578	25,276		37,939	54
57	CT SCAN	284,832	8,717		3,976		4,672	57
58	MRI	59,105			1,136		5,335	58
60	LABORATORY	438,475	111,379		21,584		47,515	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	98,427	58,858		9,656		24,983	65
66	PHYSICAL THERAPY	86,571	102,117	2,733	7,100			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	29,762			2,272			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	78,975	17,434	489			2,121	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,184						72
73	DRUGS CHARGED TO PATIENTS	90,108						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	32,214	37,175		13,348		30,848	88
90	CLINIC	15,748	21,139				9,079	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	138,081	59,494	12,989	25,276		54,937	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)	1,793,392	839,453	89,048	257,587	288,670	409,842	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		18,887		3,692		6,329	190
192	PHYSICIANS' PRIVATE OFFICES		4,885		9,088		3,711	192
192.01	TEMPORARILY IDLE SPACE		239,575					192.01
192.02	STH FAM HLTH CRT	76,698	65,814				18,555	192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,870,090	1,168,614	89,048	270,367	288,670	438,437	202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION 13	PURCHASING 14.01	CENTRAL SERVICES & SUPPLY 14.02	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	157,497						13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING		191,604					14.01
14.02	CENTRAL SERVICES & SUPPLY		402	5,798				14.02
15	PHARMACY		1,069		1,446,873			15
16	MEDICAL RECORDS & LIBRARY		526			483,290		16
17	SOCIAL SERVICE						85,980	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	77,728	11,496			142,018	85,980	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	24,045	24,650	33		38,635		50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC		14,443			2,146		54
57	CT SCAN		6,148					57
58	MRI		1,474					58
60	LABORATORY		107,588			172,425		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		4,758			20,390		65
66	PHYSICAL THERAPY		1,046	4		29,334		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		463			11,090		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			3,335				71
72	IMPL. DEV. CHARGED TO PATIENTS			2,025				72
73	DRUGS CHARGED TO PATIENTS				1,446,873			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	19,800	4,237			12,520		88
90	CLINIC		1,542					90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	35,924	6,531			54,732		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)	157,497	186,373	5,397	1,446,873	483,290	85,980	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		959	319				190
192	PHYSICIANS' PRIVATE OFFICES		13					192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		4,259	82				192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	157,497	191,604	5,798	1,446,873	483,290	85,980	202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
	GENERAL SERVICE COST CENTERS					
1	CAP REL COSTS-BLDG & FIXT					1
2	CAP REL COSTS-MVBLE EQUIP					2
4	EMPLOYEE BENEFITS DEPARTMENT					4
5.01	ADMINISTRATIVE & ACCOUNTING					5.01
5.02	BUSINESS SERVICES					5.02
6	MAINTENANCE & REPAIRS					6
7	OPERATION OF PLANT					7
8	LAUNDRY & LINEN SERVICE					8
9	HOUSEKEEPING					9
10	DIETARY					10
11	CAFETERIA					11
12	MAINTENANCE OF PERSONNEL					12
13	NURSING ADMINISTRATION					13
14	CENTRAL SERVICES & SUPPLY					14
14.01	PURCHASING					14.01
14.02	CENTRAL SERVICES & SUPPLY					14.02
15	PHARMACY					15
16	MEDICAL RECORDS & LIBRARY					16
17	SOCIAL SERVICE					17
19	NONPHYSICIAN ANESTHETISTS					19
20	NURSING SCHOOL					20
21	I&R SERVICES-SALARY & FRINGES APPRVD					21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD					22
23	PARAMED ED PRGM-(SPECIFY)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS	3,796,461		3,796,461		30
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	1,823,420		1,823,420		50
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC	1,714,087		1,714,087		54
57	CT SCAN	568,323		568,323		57
58	MRI	583,770		583,770		58
60	LABORATORY	2,891,116		2,891,116		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	833,783		833,783		65
66	PHYSICAL THERAPY	1,201,198		1,201,198		66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY	120,757		120,757		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	713,416		713,416		71
72	IMPL. DEV. CHARGED TO PATIENTS	349,692		349,692		72
73	DRUGS CHARGED TO PATIENTS	1,536,981		1,536,981		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	1,026,237		1,026,237		88
90	CLINIC	283,900		283,900		90
90.01	SALEM MEDICAL CLINIC					90.01
91	EMERGENCY	2,552,654		2,552,654		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)	19,995,795		19,995,795		118
	NONREIMBURSABLE COST CENTERS					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	180,394		180,394		190
192	PHYSICIANS' PRIVATE OFFICES	91,183		91,183		192
192.01	TEMPORARILY IDLE SPACE	457,607		457,607		192.01
192.02	STH FAM HLTH CRT	1,061,069		1,061,069		192.02
200	CROSS FOOT ADJUSTMENTS					200
201	NEGATIVE COST CENTER					201
202	TOTAL (sum of lines 118-201)	21,786,048		21,786,048		202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	EMPLOYEE BENEFITS DEPARTMENT 4	ADMINISTRA TIVE & ACC OUNTING 5.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		8,649	1,154	9,803	9,803		4
5.01	ADMINISTRATIVE & ACCOUNTING		359,736	16,905	376,641	706	377,347	5.01
5.02	BUSINESS SERVICES		96,525	311,783	408,308	683	32,390	5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		189,246	22,912	212,158	266	20,241	7
8	LAUNDRY & LINEN SERVICE		13,496	57	13,553	32	1,266	8
9	HOUSEKEEPING		11,763	26	11,789	136	4,351	9
10	DIETARY		43,539	2,341	45,880	83	3,964	10
11	CAFETERIA					218	7,594	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		8,711	605	9,316	98	2,457	13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING		20,550	371	20,921	105	2,779	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	PHARMACY		10,781	2,010	12,791	52	24,692	15
16	MEDICAL RECORDS & LIBRARY		27,543	22,378	49,921	180	7,464	16
17	SOCIAL SERVICE					64	1,431	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		84,149	59,052	143,201	2,149	46,502	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM		92,384	169,799	262,183	714	24,787	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC		44,413	179,728	224,141	652	24,103	54
57	CT SCAN		7,361	2,797	10,158	90	4,503	57
58	MRI			360,899	360,899	97	8,950	58
60	LABORATORY		94,056	93,979	188,035	687	34,504	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		49,704	17,791	67,495	352	10,682	65
66	PHYSICAL THERAPY		86,234	4,348	90,582		16,840	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY			8,685	8,685	78	1,337	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		14,723	328	15,051	18	10,584	71
72	IMPL. DEV. CHARGED TO PATIENTS						6,001	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		31,393	2,802	34,195	570	15,174	88
90	CLINIC		17,851	6,852	24,703	164	4,094	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY		50,241	35,552	85,793	1,045	37,493	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)		1,363,048	1,323,154	2,686,202	9,239	354,183	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		15,949	4,153	20,102	56	2,602	190
192	PHYSICIANS' PRIVATE OFFICES		4,125	3,789	7,914	52	1,273	192
192.01	TEMPORARILY IDLE SPACE		202,312		202,312		3,776	192.01
192.02	STH FAM HLTH CRT		55,578	6,946	62,524	456	15,513	192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		1,641,012	1,338,042	2,979,054	9,803	377,347	202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	
		5.02	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES	441,381						5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT		232,665					7
8	LAUNDRY & LINEN SERVICE		3,182	18,033				8
9	HOUSEKEEPING		2,773	1,064	20,113			9
10	DIETARY		10,265	112	570	60,874		10
11	CAFETERIA						7,812	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		2,054				94	13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING		4,845				122	14.01
14.02	CENTRAL SERVICES & SUPPLY				401			14.02
15	PHARMACY		2,542		169		92	15
16	MEDICAL RECORDS & LIBRARY		6,494		275		277	16
17	SOCIAL SERVICE						60	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	32,619	19,839	9,391	7,627	60,874	2,125	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	29,070	21,781	1,838	1,965		657	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	42,135	10,471	2,345	1,880		676	54
57	CT SCAN	67,224	1,736		296		83	57
58	MRI	13,950			85		95	58
60	LABORATORY	103,501	22,175		1,606		847	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	23,230	11,718		718		445	65
66	PHYSICAL THERAPY	20,432	20,331	554	528			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	7,024			169			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,639	3,471	99			38	71
72	IMPL. DEV. CHARGED TO PATIENTS	279						72
73	DRUGS CHARGED TO PATIENTS	21,267						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	7,603	7,401		993		550	88
90	CLINIC	3,717	4,209				162	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	32,589	11,845	2,630	1,880		979	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)	423,279	167,132	18,033	19,162	60,874	7,302	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		3,760		275		113	190
192	PHYSICIANS' PRIVATE OFFICES		973		676		66	192
192.01	TEMPORARILY IDLE SPACE		47,697					192.01
192.02	STH FAM HLTH CRT	18,102	13,103				331	192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	441,381	232,665	18,033	20,113	60,874	7,812	202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION 13	PURCHASING 14.01	CENTRAL SERVICES & SUPPLY 14.02	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	14,019						13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING		28,772					14.01
14.02	CENTRAL SERVICES & SUPPLY		60	461				14.02
15	PHARMACY		161		40,499			15
16	MEDICAL RECORDS & LIBRARY		79			64,690		16
17	SOCIAL SERVICE						1,555	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	6,919	1,726			19,010	1,555	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	2,140	3,701	3		5,171		50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC		2,169			287		54
57	CT SCAN		923					57
58	MRI		221					58
60	LABORATORY		16,157			23,081		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		714			2,729		65
66	PHYSICAL THERAPY		157			3,926		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		69			1,484		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			265				71
72	IMPL. DEV. CHARGED TO PATIENTS			161				72
73	DRUGS CHARGED TO PATIENTS				40,499			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	1,762	636			1,676		88
90	CLINIC		232					90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	3,198	981			7,326		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)	14,019	27,986	429	40,499	64,690	1,555	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		144	25				190
192	PHYSICIANS' PRIVATE OFFICES		2					192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		640	7				192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	14,019	28,772	461	40,499	64,690	1,555	202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26			
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	BUSINESS SERVICES						5.02
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY						14.02
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	353,537		353,537			30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	354,010		354,010			50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	308,859		308,859			54
57	CT SCAN	85,013		85,013			57
58	MRI	384,297		384,297			58
60	LABORATORY	390,593		390,593			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	118,083		118,083			65
66	PHYSICAL THERAPY	153,350		153,350			66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	18,846		18,846			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,165		48,165			71
72	IMPL. DEV. CHARGED TO PATIENTS	6,441		6,441			72
73	DRUGS CHARGED TO PATIENTS	61,766		61,766			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	70,560		70,560			88
90	CLINIC	37,281		37,281			90
90.01	SALEM MEDICAL CLINIC						90.01
91	EMERGENCY	185,759		185,759			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)	2,576,560		2,576,560			118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,077		27,077			190
192	PHYSICIANS' PRIVATE OFFICES	10,956		10,956			192
192.01	TEMPORARILY IDLE SPACE	253,785		253,785			192.01
192.02	STH FAM HLTH CRT	110,676		110,676			192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	2,979,054		2,979,054			202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & ACCOUNTING ACCUM COST	BUSINESS SERVICES GROSS CHARGES	
		1	2	4	5A.01	5.01	5.02	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	107,004						1
2	CAP REL COSTS-MVBLE EQUIP		1,686,455					2
4	EMPLOYEE BENEFITS DEPARTMENT	564	1,454	8,458,005				4
5.01	ADMINISTRATIVE & ACCOUNTING	23,457	21,307	609,368	-1,570,754	20,215,294		5.01
5.02	BUSINESS SERVICES	6,294	392,968	589,094		1,735,259	50,936,438	5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	12,340	28,878	229,172		1,084,358		7
8	LAUNDRY & LINEN SERVICE	880	72	27,576		67,799		8
9	HOUSEKEEPING	767	33	117,443		233,073		9
10	DIETARY	2,839	2,950	71,509		212,386		10
11	CAFETERIA			187,782		406,826		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	568	762	84,346		131,651		13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING	1,340	467	90,205		148,875		14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	PHARMACY	703	2,533	44,826		1,322,843		15
16	MEDICAL RECORDS & LIBRARY	1,796	28,205	155,506		399,847		16
17	SOCIAL SERVICE			54,944		76,645		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,487	74,429	1,856,214		2,490,915	3,764,476	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,024	214,013	615,824		1,327,937	3,354,928	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	2,896	226,528	562,133		1,291,252	4,862,667	54
57	CT SCAN	480	3,525	77,714		241,234	7,758,137	57
58	MRI		454,874	83,595		479,465	1,609,879	58
60	LABORATORY	6,133	118,450	592,395		1,848,518	11,942,775	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,241	22,423	304,122		572,247	2,680,908	65
66	PHYSICAL THERAPY	5,623	5,480			902,192	2,357,974	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		10,947	67,514		71,606	810,634	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	960	414	15,315		567,005	2,151,081	71
72	IMPL. DEV. CHARGED TO PATIENTS					321,502	32,250	72
73	DRUGS CHARGED TO PATIENTS						2,454,319	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	2,047	3,531	491,684		812,930	877,432	88
90	CLINIC	1,164	8,636	141,428		219,348	428,942	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	3,276	44,810	901,797		2,008,618	3,760,980	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	88,879	1,667,689	7,971,506	-1,570,754	18,974,331	48,847,382	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEN	1,040	5,235	48,065		139,378		190
192	PHYSICIANS' PRIVATE OFFICES	269	4,776	44,846		68,188		192
192.01	TEMPORARILY IDLE SPACE	13,192				202,312		192.01
192.02	STH FAM HLTH CRT	3,624	8,755	393,588		831,085	2,089,056	192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,641,012	1,338,042	1,947,392		1,570,754	1,870,090	202
203	UNIT COST MULT-WS B PT I	15.335987	0.793405	0.230242		0.077701	0.036714	203
204	COST TO BE ALLOC PER B PT II			9,803		377,347	441,381	204
205	UNIT COST MULT-WS B PT II			0.001159		0.018666	0.008665	205

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	
		6	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	MAINTENANCE & REPAIRS	76,689						6
7	OPERATION OF PLANT	12,340	64,349					7
8	LAUNDRY & LINEN SERVICE	880	880	18,928				8
9	HOUSEKEEPING	767	767	1,117	952			9
10	DIETARY	2,839	2,839	118	27	7,967		10
11	CAFETERIA						13,232	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	568	568				160	13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING	1,340	1,340				206	14.01
14.02	CENTRAL SERVICES & SUPPLY				19			14.02
15	PHARMACY	703	703		8		155	15
16	MEDICAL RECORDS & LIBRARY	1,796	1,796		13		469	16
17	SOCIAL SERVICE						102	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	5,487	5,487	9,857	361	7,967	3,602	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	6,024	6,024	1,929	93		1,113	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	2,896	2,896	2,461	89		1,145	54
57	CT SCAN	480	480		14		141	57
58	MRI				4		161	58
60	LABORATORY	6,133	6,133		76		1,434	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	3,241	3,241		34		754	65
66	PHYSICAL THERAPY	5,623	5,623	581	25			66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY				8			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	960	960	104			64	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC	2,047	2,047		47		931	88
90	CLINIC	1,164	1,164				274	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	3,276	3,276	2,761	89		1,658	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	58,564	46,224	18,928	907	7,967	12,369	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,040	1,040		13		191	190
192	PHYSICIANS' PRIVATE OFFICES	269	269		32		112	192
192.01	TEMPORARILY IDLE SPACE	13,192	13,192					192.01
192.02	STH FAM HLTH CRT	3,624	3,624				560	192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I		1,168,614	89,048	270,367	288,670	438,437	202
203	UNIT COST MULT-WS B PT I		18,160,562	4,704,565	283,998,950	36,233,212	33,134,598	203
204	COST TO BE ALLOC PER B PT II		232,665	18,033	20,113	60,874	7,812	204
205	UNIT COST MULT-WS B PT II		3,615,674	0,952,716	21,127,101	7,640,768	0,590,387	205

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINISTRATION DIRECT NRSING HRS	PURCHASING COSTED REQUIS.	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	
		13	14.01	14.02	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	151,681						13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING		1,208,127					14.01
14.02	CENTRAL SERVICES & SUPPLY		2,534	920,393				14.02
15	PHARMACY		6,741		1,000			15
16	MEDICAL RECORDS & LIBRARY		3,317			1,351		16
17	SOCIAL SERVICE						3,273	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	74,858	72,485			397	3,273	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	23,157	155,424	5,210		108		50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC		91,070			6		54
57	CT SCAN		38,765					57
58	MRI		9,296					58
60	LABORATORY		678,378			482		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		30,000			57		65
66	PHYSICAL THERAPY		6,596	602		82		66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY		2,917			31		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			529,401				71
72	IMPL. DEV. CHARGED TO PATIENTS			321,502				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	19,069	26,717			35		88
90	CLINIC		9,724					90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	34,597	41,181	22		153		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)	151,681	1,175,145	856,737	1,000	1,351	3,273	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		6,046	50,630				190
192	PHYSICIANS' PRIVATE OFFICES		80					192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		26,856	13,026				192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	157,497	191,604	5,798	1,446,873	483,290	85,980	202
203	UNIT COST MULT-WS B PT I	1.038344	0.158596	0.006299	1,446.873000	357.727609	26.269478	203
204	COST TO BE ALLOC PER B PT II	14,019	28,772	461	40,499	64,690	1,555	204
205	UNIT COST MULT-WS B PT II	0.092424	0.023815	0.000501	40.499000	47.883050	0.475099	205

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS							
--	--------------------------	--	--	--	--	--	--	--

	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	PHARMACY							15
16	MEDICAL RECORDS & LIBRARY							16
17	SOCIAL SERVICE							17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-(SPECIFY)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS							30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
57	CT SCAN							57
58	MRI							58
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
90	CLINIC							90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY							91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT							192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I							202
203	UNIT COST MULT-WS B PT I							203
204	COST TO BE ALLOC PER B PT II							204
205	UNIT COST MULT-WS B PT II							205

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT
		PART	LINE NO.	
	1	2	3	4

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	3,796,461		3,796,461		3,796,461	30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	1,823,420		1,823,420		1,823,420	50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC	1,714,087		1,714,087		1,714,087	54
57	CT SCAN	568,323		568,323		568,323	57
58	MRI	583,770		583,770		583,770	58
60	LABORATORY	2,891,116		2,891,116		2,891,116	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	833,783		833,783		833,783	65
66	PHYSICAL THERAPY	1,201,198		1,201,198		1,201,198	66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY	120,757		120,757		120,757	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	713,416		713,416		713,416	71
72	IMPL. DEV. CHARGED TO PATIENTS	349,692		349,692		349,692	72
73	DRUGS CHARGED TO PATIENTS	1,536,981		1,536,981		1,536,981	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	1,026,237		1,026,237		1,026,237	88
90	CLINIC	283,900		283,900		283,900	90
90.01	SALEM MEDICAL CLINIC						90.01
91	EMERGENCY	2,552,654		2,552,654		2,552,654	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	407,809		407,809		407,809	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 (SEE INSTRUCTIONS)	20,403,604		20,403,604		20,403,604	200
201	LESS OBSERVATION BEDS	407,809		407,809		407,809	201
202	TOTAL (SEE INSTRUCTIONS)	19,995,795		19,995,795		19,995,795	202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	3,370,385		3,370,385				30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	670,814	2,684,114	3,354,928	0.543505	0.543505	0.543505	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	352,197	4,510,470	4,862,667	0.352499	0.352499	0.352499	54
57	CT SCAN	480,602	7,277,535	7,758,137	0.073255	0.073255	0.073255	57
58	MRI	55,732	1,554,147	1,609,879	0.362617	0.362617	0.362617	58
60	LABORATORY	1,348,431	10,594,344	11,942,775	0.242081	0.242081	0.242081	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,270,041	1,410,867	2,680,908	0.311008	0.311008	0.311008	65
66	PHYSICAL THERAPY	329,174	2,028,800	2,357,974	0.509420	0.509420	0.509420	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	44,280	766,354	810,634	0.148966	0.148966	0.148966	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	682,617	1,179,741	1,862,358	0.383071	0.383071	0.383071	71
72	IMPL. DEV. CHARGED TO PATIENTS	212,184	108,789	320,973	1.089475	1.089475	1.089475	72
73	DRUGS CHARGED TO PATIENTS	870,345	1,583,974	2,454,319	0.626235	0.626235	0.626235	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		877,432	877,432				88
90	CLINIC	2,100	426,842	428,942	0.661861	0.661861	0.661861	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	2,500	3,758,480	3,760,980	0.678720	0.678720	0.678720	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		394,091	394,091	1.034809	1.034809	1.034809	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 (SEE INSTRUCTIONS)	9,691,402	39,155,980	48,847,382				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	9,691,402	39,155,980	48,847,382				202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	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.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.543505		1,484,460			806,811	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	0.352499		1,952,553			688,273	54
57	CT SCAN	0.073255		3,201,874			234,553	57
58	MRI	0.362617		676,085			245,160	58
60	LABORATORY	0.242081		3,662,808			886,696	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.311008		689,949			214,580	65
66	PHYSICAL THERAPY	0.509420		886,739			451,723	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	0.148966		432,036			64,359	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.383071		518,306			198,548	71
72	IMPL. DEV. CHARGED TO PATIENTS	1.089475		85,559			93,214	72
73	DRUGS CHARGED TO PATIENTS	0.626235		933,398			584,526	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	RURAL HEALTH CLINIC							88
90	CLINIC	0.661861		240,431			159,132	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	0.678720		1,302,112			883,769	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.034809		209,572			216,867	92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)			16,275,882			5,728,211	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)			16,275,882			5,728,211	202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z345

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [XX] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.543505							50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.352499							54
57	CT SCAN	0.073255							57
58	MRI	0.362617							58
60	LABORATORY	0.242081							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.311008							65
66	PHYSICAL THERAPY	0.509420							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.148966							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.383071							71
72	IMPL. DEV. CHARGED TO PATIENTS	1.089475							72
73	DRUGS CHARGED TO PATIENTS	0.626235							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
90	CLINIC	0.661861							90
90.01	SALEM MEDICAL CLINIC								90.01
91	EMERGENCY	0.678720							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.034809							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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII, PART A
 BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26))	SWING BED ADJUSTMENT	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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	353,537	49,630	303,907	3,089	98.38	71	6,985	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)	353,537		303,907	3,089		71	6,985	200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] TITLE XVIII, PART A [] IPF
 BOXES: [XX] TITLE XIX [] IRF

(A)	COST CENTER DESCRIPTION	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)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	354,010	3,354,928	0.105519		50
53	ANESTHESIOLOGY					53
54	RADIOLOGY-DIAGNOSTIC	308,859	4,862,667	0.063516		54
57	CT SCAN	85,013	7,758,137	0.010958		57
58	MRI	384,297	1,609,879	0.238712		58
60	LABORATORY	390,593	11,942,775	0.032705		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	118,083	2,680,908	0.044046		65
66	PHYSICAL THERAPY	153,350	2,357,974	0.065035		66
67	OCCUPATIONAL THERAPY					67
68	SPEECH PATHOLOGY					68
69	ELECTROCARDIOLOGY	18,846	810,634	0.023248		69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,165	1,862,358	0.025862		71
72	IMPL. DEV. CHARGED TO PATIENTS	6,441	320,973	0.020067		72
73	DRUGS CHARGED TO PATIENTS	61,766	2,454,319	0.025166		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	70,560	877,432	0.080416		88
90	CLINIC	37,281	428,942	0.086914		90
90.01	SALEM MEDICAL CLINIC					90.01
91	EMERGENCY	185,759	3,760,980	0.049391		91
92	OBSERVATION BEDS (NON-DISTINCT PART)	44,178	394,091	0.112101		92
	OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (sum of lines 50-199)	2,267,201	45,476,997			200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII, PART A
 BOXES: [XX] TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV 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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK [] TITLE V
 APPLICABLE [] TITLE XVIII, PART A
 BOXES: [XX] TITLE XIX

(A)	COST CENTER DESCRIPTION	TOTAL PATIENT DAYS	PER DIEM (col. 5+ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	3,089		71		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)	3,089		71		200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	ALLIED HEALTH	ALL OTHER MEDICAL EDUCATION COST	TOTAL COST (sum of col. 1 through col. 4)	TOTAL OUTPATIENT COST (sum of col. 2, 3, and 4)
		1	2	3	4	5	6
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	CT SCAN						57
58	MRI						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC						88
90	CLINIC						90
90.01	SALEM MEDICAL CLINIC						90.01
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)						200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5+ col. 7)	OUTPAT- IENT RATIO OF COST TO CHARGES (col. 6+ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS- THROUGH COSTS (col. 8 x col. 10)	OUTPAT- IENT PROGRAM CHARGES	OUTPAT- IENT PROGRAM PASS- THROUGH COSTS (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	OPERATING ROOM	3,354,928							50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	4,862,667							54
57	CT SCAN	7,758,137							57
58	MRI	1,609,879							58
60	LABORATORY	11,942,775							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	2,680,908							65
66	PHYSICAL THERAPY	2,357,974							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	810,634							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,862,358							71
72	IMPL. DEV. CHARGED TO PATIENTS	320,973							72
73	DRUGS CHARGED TO PATIENTS	2,454,319							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	877,432							88
90	CLINIC	428,942							90
90.01	SALEM MEDICAL CLINIC								90.01
91	EMERGENCY	3,760,980							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	394,091							92
OTHER REIMBURSABLE COST CENTERS									
200	TOTAL (sum of lines 50-199)	45,476,997							200

(A) Worksheet A line numbers

Optimizer Systems, Inc.

Win LASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	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.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.543505							50
53	ANESTHESIOLOGY								53
54	RADIOLOGY-DIAGNOSTIC	0.352499							54
57	CT SCAN	0.073255							57
58	MRI	0.362617							58
60	LABORATORY	0.242081							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.311008							65
66	PHYSICAL THERAPY	0.509420							66
67	OCCUPATIONAL THERAPY								67
68	SPEECH PATHOLOGY								68
69	ELECTROCARDIOLOGY	0.148966							69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.383071							71
72	IMPL. DEV. CHARGED TO PATIENTS	1.089475							72
73	DRUGS CHARGED TO PATIENTS	0.626235							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	RURAL HEALTH CLINIC								88
90	CLINIC	0.661861							90
90.01	SALEM MEDICAL CLINIC								90.01
91	EMERGENCY	0.678720							91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.034809							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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] 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)	3,659	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,089	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,703	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	332	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)	164	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	50	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)	24	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,968	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)	332	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)	164	11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	3,796,461	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)	6,032	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	2,895	25
26	TOTAL SWING-BED COST (see instructions)	532,946	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,263,515	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 - line 36)	3,263,515	37

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,056.49	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					2,079,172	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					2,079,172	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

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					1,487,978	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					3,567,150	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet 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 ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)	350,755	64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)	173,264	65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)	524,019	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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					386	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,056.50	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					407,809	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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	353,537	3,263,515	0.108330	407,809	44,178	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [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)	3,659	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,089	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	2,703	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	332	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)	164	6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	50	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)	24	8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	71	9
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions)		10
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		11
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		12
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V OR XIX ONLY (including private room days) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (if calendar year, enter 0 on this line)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	120.63	20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	3,796,461	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)	6,032	24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)	2,895	25
26	TOTAL SWING-BED COST (see instructions)	532,946	26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,263,515	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 - line 36)	3,263,515	37

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [XX] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,056.49	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					75,011	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)					75,011	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

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					75,011	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					6,985	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					6,985	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (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 ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					386	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 + line 2)						88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)						89
		COST	ROUTINE COST (from line 27)	column 1 + column 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 COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1345

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		1,982,092		30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.543505	388,771	211,299	50
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.352499	247,389	87,204	54
57	CT SCAN	0.073255	269,977	19,777	57
58	MRI	0.362617	37,923	13,752	58
60	LABORATORY	0.242081	949,892	229,951	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.311008	922,065	286,770	65
66	PHYSICAL THERAPY	0.509420	75,960	38,696	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.148966	30,171	4,494	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.383071	578,580	221,637	71
72	IMPL. DEV. CHARGED TO PATIENTS	1.089475	26,670	29,056	72
73	DRUGS CHARGED TO PATIENTS	0.626235	548,022	343,191	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
90	CLINIC	0.661861	1,155	764	90
90.01	SALEM MEDICAL CLINIC				90.01
91	EMERGENCY	0.678720	2,044	1,387	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.034809			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		4,078,619	1,487,978	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		4,078,619		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z345

WORKSHEET D-3

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] SWING BED SNF [] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.543505			50
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.352499	38,243	13,481	54
57	CT SCAN	0.073255			57
58	MRI	0.362617			58
60	LABORATORY	0.242081	66,332	16,058	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.311008	33,969	10,565	65
66	PHYSICAL THERAPY	0.509420	229,811	117,070	66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.148966	720	107	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.383071	58,319	22,340	71
72	IMPL. DEV. CHARGED TO PATIENTS	1.089475			72
73	DRUGS CHARGED TO PATIENTS	0.626235	74,382	46,581	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
90	CLINIC	0.661861			90
90.01	SALEM MEDICAL CLINIC				90.01
91	EMERGENCY	0.678720	147	100	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.034809			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		501,923	226,302	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		501,923		202

(A) Worksheet A line numbers

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1345

WORKSHEET D-3

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [XX] TITLE XIX [] IRF [] NF [] ICF/MR [XX] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.543505			50
53	ANESTHESIOLOGY				53
54	RADIOLOGY-DIAGNOSTIC	0.352499			54
57	CT SCAN	0.073255			57
58	MRI	0.362617			58
60	LABORATORY	0.242081			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.311008			65
66	PHYSICAL THERAPY	0.509420			66
67	OCCUPATIONAL THERAPY				67
68	SPEECH PATHOLOGY				68
69	ELECTROCARDIOLOGY	0.148966			69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.383071			71
72	IMPL. DEV. CHARGED TO PATIENTS	1.089475			72
73	DRUGS CHARGED TO PATIENTS	0.626235			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	RURAL HEALTH CLINIC				88
90	CLINIC	0.661861			90
90.01	SALEM MEDICAL CLINIC				90.01
91	EMERGENCY	0.678720			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1.034809			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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1345

WORKSHEET E
PART BCHECK APPLICABLE BOX: 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)	5,728,211			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 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	5,728,211			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, line 69, col. 4)				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 REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	5,785,493			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)	51,630			25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	2,623,331			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	3,110,532			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)	3,110,532			30
31	PRIMARY PAYER PAYMENTS	3,501			31
32	SUBTOTAL (line 30 minus line 31)	3,107,031			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)	484,429			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	426,298			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	435,198			36
37	SUBTOTAL (see instructions)	3,533,329			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	3,533,329			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	70,667			40.01
41	INTERIM PAYMENTS	4,441,935			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-979,273			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see 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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1345

WORKSHEET E-1
PART I

CHECK [XX] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOXES: [] IRF [] SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT		
		1	2	3	4		
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		3,629,364		4,427,582	1	
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					2	
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT			06/03/2013	4,997	3.01	
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM			09/24/2013	9,356	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	06/03/2013	56,000	3.51	
		PROVIDER	.52	09/24/2013	216,043	3.52	
		TO	.53	03/25/2014	69,028	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		-341,071	14,353	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)				3,288,293	4,441,935	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		-43,197	-908,606	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				3,245,096	3,533,329	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.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-Z345

WORKSHEET E-1
PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [] IPF [] SNF
 BOXES: [] IRF [XX] SWING BED SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		794,114		1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT	.01	06/30/2013	85	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	09/24/2013	4,958
		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		-4,873	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)			789,241	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		-34,529	6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			754,712	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.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

CHECK HOSPITAL CAH
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	737	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	1,968	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	20	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	2,703	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	48,847,382	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	667,723	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168	34,038	7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	32,190	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	644	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	31,546	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)		30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	31,546	32

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z345

WORKSHEET E-2

CHECK [] TITLE V [XX] SWING BED - SNF
 APPLICABLE [XX] TITLE XVIII [] SWING BED - NF
 BOXES: [] TITLE XIX

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	INPATIENT ROUTINE SERVICES - SWING BED-SNF (see instructions)	529,259		1
2	INPATIENT ROUTINE SERVICES - SWING BED-NF (see instructions)			2
3	ANCILLARY SERVICES (from Wkst D-3, col. 3, line 200 for Part A, and sum of Wkst D, Part V, cols: 5 and 7, line 202 for Part B) (for CAH, see instructions)	228,565		3
4	PER DIEM COST FOR INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			4
5	PROGRAM DAYS	496		5
6	INTERNS AND RESIDENTS NOT IN APPROVED TEACHING PROGRAM (see instructions)			6
7	UTILIZATION REVIEW - PHYSICIAN COMPENSATION - SNF OPTIONAL METHOD ONLY			7
8	SUBTOTAL (sum of lines 1-3 plus lines 6 and 7)	757,824		8
9	PRIMARY PAYER PAYMENTS (see instructions)			9
10	SUBTOTAL (line 8 minus line 9)	757,824		10
11	DEDUCTIBLES BILLED TO PROGRAM PATIENTS (exclude amounts applicable to physician professional services)			11
12	SUBTOTAL (line 10 minus line 11)	757,824		12
13	COINSURANCE BILLED TO PROGRAM PATIENTS (exclude coinsurance for physician professional services)		3,112	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)	754,712		15
16	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			16
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)	754,712		19
19.01	SEQUESTRATION ADJUSTMENT (see instructions)		15,094	19.01
20	INTERIM PAYMENTS		789,241	20
21	TENTATIVE SETTLEMENT (for contractor use only)			21
22	BALANCE DUE PROVIDER/PROGRAM (line 19 minus lines 19.01, 20 and 21)		-49,623	22
23	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			23

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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	3,567,150	1
2	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		2
3	ORGAN ACQUISITION		3
4	SUBTOTAL (sum of lines 1-3)	3,567,150	4
5	PRIMARY PAYER PAYMENTS	10,245	5
6	TOTAL COST (line 4 less line 5) (for CAH, see instructions)	3,592,577	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 TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49)		18
19	COST OF COVERED SERVICES (sum of lines 6 and 17)	3,592,577	19
20	DEDUCTIBLES (exclude professional component)	412,992	20
21	EXCESS REASONABLE COST (from line 16)		21
22	SUBTOTAL (line 19 minus the sum of lines 20 and 21)	3,179,585	22
23	COINSURANCE		23
24	SUBTOTAL (line 22 minus line 23)	3,179,585	24
25	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	74,444	25
26	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	65,511	26
27	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	64,188	27
28	SUBTOTAL (sum of lines 24 and 26)	3,245,096	28
29	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		29
30	SUBTOTAL (line 28 plus or minus line 29)	3,245,096	30
30.01	SEQUESTRATION ADJUSTMENT (see instructions)	64,902	30.01
31	INTERIM PAYMENTS	3,288,293	31
32	TENTATIVE SETTLEMENT (for contractor use only)		32
33	BALANCE DUE PROVIDER/PROGRAM (line 30 minus lines 30.01, 31 and 32)	-108,099	33
34	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		34

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1345

WORKSHEET E-3
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	75,011		1
2			2
3			3
4	75,011		4
5			5
6			6
7	75,011		7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8			8
9			9
10			10
11			11
12			12
CUSTOMARY CHARGES			
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21	75,011		21
PROSPECTIVE PAYMENT AMOUNT			
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29	75,011		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30			30
31	75,011		31
32			32
33			33
34			34
35			35
36	75,011		36
37			37
38	75,011		38
39			39
40	75,011		40
41			41
42	75,011		42
43			43

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

BALANCE SHEET

WORKSHEET G

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

ASSETS (Omit Cents)		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	4,541,837				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	7,203,010				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-2,453,264				6
7	INVENTORY	425,002				7
8	PREPAID EXPENSES	341,757				8
9	OTHER CURRENT ASSETS	1,091,128				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	11,149,470				11
FIXED ASSETS						
12	LAND	99,382				12
13	LAND IMPROVEMENTS	1,140,199				13
14	ACCUMULATED DEPRECIATION	-697,637				14
15	BUILDINGS	31,003,545				15
16	ACCUMULATED DEPRECIATION	-8,451,324				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	2,037,664				19
20	ACCUMULATED DEPRECIATION	-1,080,005				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	8,936,313				23
24	ACCUMULATED DEPRECIATION	-7,075,143				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS	1,113,307				27
28	ACCUMULATED DEPRECIATION	-703,317				28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	26,322,984				30
OTHER ASSETS						
31	INVESTMENTS	3,026,033				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	1,535,907				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	4,561,940				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	42,034,394				36
LIABILITIES AND FUND BALANCES (Omit Cents)						
		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	1,998,346				37
38	SALARIES, WAGES & FEES PAYABLE	1,073,167				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)	214,001				40
41	DEFERRED INCOME	86,794				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS	1,267,303				43
44	OTHER CURRENT LIABILITIES	185,191				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	4,824,802				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE	11,305,000				46
47	NOTES PAYABLE	1,802,815				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES					49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	13,107,815				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	17,932,617				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	24,101,777				52
53	SPECIFIC PURPOSE FUND BALANCE					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 52-58)	24,101,777				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	42,034,394				60

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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		23,271,518			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		830,259			2
3	TOTAL (sum of line 1 and line 2)		24,101,777			3
4	ADDITIONS (credit adjustments)					4
5						5
6						6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)		24,101,777			11
12	DEDUCTIONS (debit adjustments)					12
13						13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		24,101,777			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)					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)					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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	2,731,208		2,731,208	1
2	SUBPROVIDER IPF				2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF	359,396		359,396	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)	3,090,604		3,090,604	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)	3,090,604		3,090,604	17
18	ANCILLARY SERVICES	6,823,247		6,823,247	18
19	OUTPATIENT SERVICES		41,466,053	41,466,053	19
20	RHC		915,260	915,260	20
21	FOHC				21
22	HOME HEALTH AGENCY				22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	9,913,851	42,381,313	52,295,164	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		24,885,766	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)		24,885,766	43

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	52,295,164	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	27,683,469	2
3	NET PATIENT REVENUES (line 1 minus line 2)	24,611,695	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	24,885,766	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-274,071	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	4,290	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	527	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	139,587	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	454	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS		18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	69,232	20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (PROPERTY TAX REVENUE)	247,050	24
24.01	OTHER (OTHER OPERATING INCOME (EXPENSE))	241,447	24.01
24.02	OTHER (NONCAPITAL GRANTS AND CONTRIBUTIONS)	3,717	24.02
24.03	OTHER (CAPITAL GRANTS AND CONTRIBUTIONS)	398,026	24.03
25	TOTAL OTHER INCOME (sum of lines 6-24)	1,104,330	25
26	TOTAL (line 5 plus line 25)	830,259	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	830,259	29

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7429

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL						5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE						6
7	PHYSICAL THERAPY						7
8	OCCUPATIONAL THERAPY						8
9	SPEECH PATHOLOGY						9
10	MEDICAL SOCIAL SERVICES						10
11	HOME HEALTH AIDE						11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)						24

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7429

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL						5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE						6
7	PHYSICAL THERAPY						7
8	OCCUPATIONAL THERAPY						8
9	SPEECH PATHOLOGY						9
10	MEDICAL SOCIAL SERVICES						10
11	HOME HEALTH AIDE						11
12	SUPPLIES (see instructions)						12
13	DRUGS						13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)						24

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7429

WORKSHEET H-1
PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL					5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE					6
7	PHYSICAL THERAPY					7
8	OCCUPATIONAL THERAPY					8
9	SPEECH PATHOLOGY					9
10	MEDICAL SOCIAL SERVICES					10
11	HOME HEALTH AIDE					11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)					24

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7429

WORKSHEET H-1
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL					5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE					6
7	PHYSICAL THERAPY					7
8	OCCUPATIONAL THERAPY					8
9	SPEECH PATHOLOGY					9
10	MEDICAL SOCIAL SERVICES					10
11	HOME HEALTH AIDE					11
12	SUPPLIES (see instructions)					12
13	DRUGS					13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)					24

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7429

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTER								
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL							5
HHA REIMBURSABLE SERVICES								
6	SKILLED NURSING CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	HOME HEALTH AIDE							11
12	SUPPLIES (see instructions)							12
13	DRUGS							13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)							24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)							25
26	UNIT COST MULTIPLIER							26

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7429

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	ADMINISTRA TIVE & ACC OUNTING	
		0	1	2	4	4A	5.01	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)							20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7429

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	BUSINESS S ERVICES	MAIN- TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	
		5.02	6	7	8	9	10	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)							20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7429

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	CAFETERIA	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PURCHASING	CENTRAL SERVICES & SUPPLY	
		11	12	13	14	14.01	14.02	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)							20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7429

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	PHARMACY 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE 17	NONPHYSIC. ANESTHET. 19	NURSING SCHOOL 20	I&R SALARY & FRINGES 21	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)							20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7429

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (sum of col.4A-23)	ALLOCATED HHA A&G (see Pt.2)	
		22	23	24	25	26	27	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)							20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.							21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7429

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	TOTAL HHA COSTS					
		28					
1	ADMINISTRATIVE AND GENERAL						1
2	SKILLED NURSING CARE						2
3	PHYSICAL THERAPY						3
4	OCCUPATIONAL THERAPY						4
5	SPEECH PATHOLOGY						5
6	MEDICAL SOCIAL SERVICES						6
7	HOME HEALTH AIDE						7
8	SUPPLIES						8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
20	TOTALS (sum of lines 1-19)(2)						20
21	UNIT COST MULTIPLIER: COLUMN 26, LINE 1 DIVIDED BY THE SUM OF COLUMN 26, LINE 20 MINUS COLUMN 26, LINE 1, ROUNDED TO 6 DECIMAL PLACES.						21

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

Optimizer Systems, Inc.

Win LASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7429

WORKSHEET H-2
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINISTRA TIVE & ACC OUNTING ACCUM COST	BUSINESS S ERVICES GROSS CHAR GES	
		1	2	4	4A.01	5.01	5.02	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7429

WORKSHEET H-2
PART II

	HHA COST CENTER	MAIN- TENANCE & REPAIRS SQUARE FEET	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE- KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	
		6	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7429

WORKSHEET H-2
PART II

	HHA COST CENTER	MAIN- TENANCE OF PERSONNEL NUMBER HOUSED	NURSING ADMINIS- TRATION DIRECT NRSING HRS	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PURCHASING COSTED REQUIS.	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	PHARMACY COSTED REQUIS.	
		12	13	14	14.01	14.02	15	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7429

WORKSHEET H-2
PART II

	HHA COST CENTER	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	
		16	17	19	20	21	22	
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---------------------------------------	--	---

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7429

WORKSHEET H-2
PART II

	HHA COST CENTER	PARAMED EDUCATION ASSIGNED TIME						
		23						
1	ADMINISTRATIVE AND GENERAL							1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)							20
21	TOTAL COST TO BE ALLOCATED							21
22	UNIT COST MULTIPLIER							22
22	UNIT COST MULTIPLIER							22

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7429

WORKSHEET H-3
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION							
	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PER VISIT (col. 3 ÷ col. 4)
			1	2	3	4	5
1	SKILLED NURSING CARE	2					1
2	PHYSICAL THERAPY	3					2
3	OCCUPATIONAL THERAPY	4					3
4	SPEECH PATHOLOGY	5					4
5	MEDICAL SOCIAL SERVICES	6					5
6	HOME HEALTH AIDE	7					6
7	TOTAL (sum of lines 1-6)						7

LIMITATION COST COMPUTATION				PROGRAM VISITS	
	PATIENT SERVICES	CBSA NO.	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE
		1	2	3	4
8	SKILLED NURSING CARE	16460			8
9	PHYSICAL THERAPY	16460			9
10	OCCUPATIONAL THERAPY	16460			10
11	SPEECH PATHOLOGY	16460			11
12	MEDICAL SOCIAL SERVICES	16460			12
13	HOME HEALTH AIDE	16460			13
14	TOTAL (sum of lines 8-13)				14

SUPPLIES AND DRUGS COSTS COMPUTATIONS							
	OTHER PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL CHARGES (from HHA Record)	RATIO (col. 3 ÷ col. 4)
			1	2	3	4	5
15	COST OF MEDICAL SUPPLIES	8					15
16	COST OF DRUGS	9					16

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

		FROM WKST. C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records)	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED
			1	2	3	4
1	PHYSICAL THERAPY	66	0.509420			col. 2, line 2
2	OCCUPATIONAL THERAPY	67				col. 2, line 3
3	SPEECH PATHOLOGY	68				col. 2, line 4
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.383071			col. 2, line 15
5	DRUGS CHARGED TO PATIENTS	73	0.626235			col. 2, line 16

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7429

WORKSHEET H-3
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		PROGRAM VISITS			COST OF SERVICES			TOTAL PROGRAM COST (sum of cols 9-10)
		PART B			PART B			
PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
	6	7	8	9	10	11	12	
1 SKILLED NURSING CARE							1	
2 PHYSICAL THERAPY							2	
3 OCCUPATIONAL THERAPY							3	
4 SPEECH PATHOLOGY							4	
5 MEDICAL SOCIAL SERVICES							5	
6 HOME HEALTH AIDE							6	
7 TOTAL (sum of lines 1-6)							7	

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES		
		PART B			PART B		
OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
	6	7	8	9	10	11	
15 COST OF MEDICAL SUPPLIES							15
16 COST OF DRUGS							16

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7429

WORKSHEET H-4
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

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

	DESCRIPTION	PART A 1	PART B		
			NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)				1
2	TOTAL CHARGES				2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)				3
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(b)				4
5	RATIO OF LINE 3 TO LINE 4 (not to exceed 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)				6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)				7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)				8
9	PRIMARY PAYER PAYMENTS				9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES 1	PART B SERVICES 2	
10	TOTAL REASONABLE COST (see instructions)			10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS			11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES			13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES			14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS			15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES			16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)			22
23	EXCESS REASONABLE COST (from line 8)			23
24	SUBTOTAL (line 22 minus line 23)			24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)			26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)			29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)			31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)			31.01
32	INTERIM PAYMENTS (see instructions)			32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	BUSINESS SERVICES						5.02
6	MAINTENANCE & REPAIRS						6
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY						14.02
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-(SPECIFY)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
57	CT SCAN						57
58	MRI						58
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
67	OCCUPATIONAL THERAPY						67
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	RURAL HEALTH CLINIC						88
90	CLINIC						90
90.01	SALEM MEDICAL CLINIC						90.01
91	EMERGENCY						91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
192.01	TEMPORARILY IDLE SPACE						192.01
192.02	STH FAM HLTH CRT						192.02
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)						202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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

COMPONENT CCN: 14-3413

WORKSHEET M-1

CHECK APPLICABLE BOX: [XX] RHC [] FQHC

		COMPENSATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSIFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	PHYSICIAN	9,754	706	10,460		10,460		10,460	1
2	PHYSICIAN ASSISTANT								2
3	NURSE PRACTITIONER	291,820	21,115	312,935		312,935		312,935	3
4	VISITING NURSE								4
5	OTHER NURSE	21,081	1,525	22,606		22,606		22,606	5
6	CLINICAL PSYCHOLOGIST								6
7	CLINICAL SOCIAL WORKER								7
8	LABORATORY TECHNICIAN								8
9	OTHER FACILITY HEALTH CARE STAFF COSTS								9
10	SUBTOTAL (sum of lines 1-9)	322,655	23,346	346,001		346,001		346,001	10
	COSTS UNDER AGREEMENT								
11	PHYSICIAN SERVICES UNDER AGREEMENT				69,561	69,561		69,561	11
12	PHYSICIAN SUPERVISION UNDER AGREEMENT								12
13	OTHER COSTS UNDER AGREEMENT								13
14	SUBTOTAL (sum of lines 11-13)				69,561	69,561		69,561	14
	OTHER HEALTH CARE COSTS								
15	MEDICAL SUPPLIES		21,276	21,276		21,276		21,276	15
16	TRANSPORTATION (Health Care Staff)								16
17	DEPRECIATION-MEDICAL EQUIPMENT								17
18	PROFESSIONAL LIABILITY INSURANCE								18
19	OTHER HEALTH CARE COSTS								19
20	ALLOWABLE GME COSTS								20
21	SUBTOTAL (sum of lines 15-20)		21,276	21,276		21,276		21,276	21
22	TOTAL COST OF HEALTH CARE SERVICES (sum of lines 10, 14, and 21)	322,655	44,622	367,277	69,561	436,838		436,838	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	PHARMACY								23
24	DENTAL								24
25	OPTOMETRY								25
26	ALL OTHER NONREIMBURSABLE COSTS								26
27	NONALLOWABLE GME COSTS								27
28	TOTAL NONREIMBURSABLE COSTS (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	FACILITY COSTS								29
30	ADMINISTRATIVE COSTS	169,029	59,662	228,691		228,691		228,691	30
31	TOTAL FACILITY OVERHEAD (sum of lines 29 and 30)	169,029	59,662	228,691		228,691		228,691	31
32	TOTAL FACILITY COSTS (sum of lines 22, 28 and 31)	491,684	104,284	595,968	69,561	665,529		665,529	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.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3413

WORKSHEET M-2

CHECK APPLICABLE BOX: RHC FQHC

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL	TOTAL VISITS	PRODUCTIVITY STANDARD (1)	MINIMUM VISITS (col. 1 x col. 3)	GREATER OF COL. 2 OR COL. 4	
	POSITIONS	1	2	3	4	5	
1	PHYSICIANS	0.10	154	4,200	420		1
2	PHYSICIAN ASSISTANTS			2,100			2
3	NURSE PRACTITIONERS	2.67	6,646	2,100	5,607		3
4	SUBTOTAL (sum of lines 1-3)	2.77	6,800		6,027	6,800	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 4-7)	2.77	6,800			6,800	8
9	PHYSICIAN SERVICES UNDER AGREEMENTS		344			344	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	TOTAL COSTS OF HEALTH CARE SERVICES (from Worksheet M-1, column 7, line 22)		436,838	10
11	TOTAL NONREIMBURSABLE COSTS (from Worksheet M-1, column 7, line 28)			11
12	COST OF ALL SERVICES (excluding overhead) (sum of lines 10 and 11)		436,838	12
13	RATIO OF RHC/FQHC SERVICES (line 10 divided by line 12)		1.000000	13
14	TOTAL FACILITY OVERHEAD (from Worksheet M-1, column 7, line 31)		228,691	14
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (see instructions)		360,708	15
16	TOTAL OVERHEAD (sum of lines 14 and 15)		589,399	16
17	ALLOWABLE DIRECT GME OVERHEAD (see instructions)			17
18	SUBTRACT LINE 17 FROM LINE 16		589,399	18
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (line 13 x line 18)		589,399	19
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (sum of lines 10 and 19)		1,026,237	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 1 thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3413

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (from Worksheet M-2, line 20)	1,026,237	1
2	COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 15)	3,503	2
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (line 1 minus line 2)	1,022,734	3
4	TOTAL VISITS (from Worksheet M-2, column 5, line 8)	6,800	4
5	PHYSICIANS VISITS UNDER AGREEMENT (from Worksheet M-2, column 5, line 9)	344	5
6	TOTAL ADJUSTED VISITS (line 4 plus line 5)	7,144	6
7	ADJUSTED COST PER VISIT (line 3 divided by line 6)	143.16	7

		CALCULATION OF LIMIT (1)		(SEE INSTR.)	
		PRIOR TO JANUARY 1	ON OR AFTER JANUARY 1		
		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)	143.16	143.16	143.16	9
CALCULATION OF SETTLEMENT					
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (from contractor records)		899		10
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (line 9 x line 10)		128,701		11
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (from contractor records)				12
13	PROGRAM COVERED COST FROM MENTAL HEALTH SERVICES (line 9 x line 12)				13
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (see instructions)				14
15	GRADUATE MEDICAL EDUCATION PASS-THROUGH COST (see instructions)				15
16	TOTAL PROGRAM COST (sum of lines 11, 14, and 15, columns 1, 2, and 3)		128,701		16
16.01	TOTAL PROGRAM CHARGES (see instructions)(from contractor's records)		109,243		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)		81,930		16.04
16.05	TOTAL PROGRAM COST (see instructions)		81,930		16.05
17	PRIMARY PAYER PAYMENTS		159		17
18	LESS: BENEFICIARY DEDUCTIBLE FOR RHC ONLY (see instructions)(from contractor records)		26,289		18
19	LESS: BENEFICIARY COINSURANCE FOR RHC/FQHC SERVICES (see instructions) (from contractor records)		16,591		19
20	NET MEDICARE COST EXCLUDING VACCINES (see instructions)		81,771		20
21	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (from Worksheet M-4, line 16)		3,503		21
22	TOTAL REIMBURSABLE PROGRAM COST (line 20 plus line 21)		85,274		22
23	ALLOWABLE BAD DEBTS (see instructions)				23
24	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				24
25	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				25
26	NET REIMBURSABLE AMOUNT (see instructions)		85,274		26
26.01	SEQUESTRATION ADJUSTMENT (see instructions)		1,705		26.01
27	INTERIM PAYMENTS		62,448		27
28	TENTATIVE SETTLEMENT (for contractor use only)				28
29	BALANCE DUE COMPONENT/PROGRAM (line 26 minus lines 26.01, 27 and 28)		21,121		29
30	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, CHAPTER 1, SECTION 115.2				30

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

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3413

WORKSHEET M-4

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

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	HEALTH CARE STAFF COST (from Worksheet M-1, column 7, line 10)	346,001	346,001	1
2	RATIO OF PNEUMOCOCCAL AND INFLUNZA VACCINE STAFF TIME TO TOTAL HEALTH CARE STAFF TIME	0.000659	0.000659	2
3	PNEUMOCOCCAL AND INFUENZA VACCINE HEALTH CARE STAFF COST (line 1 x line 2)	228	228	3
4	MEDICAL SUPPLIES COST - PNEUMOCOCCAL AND INFUENZA VACCINE (from your records)	356	679	4
5	DIRECT COST OF PNEUMOCOCCAL AND INFLUENZA VACCINE (line 3 plus line 4)	584	907	5
6	TOTAL DIRECT COST OF THE FACILITY (from Worksheet M-1, column 7, line 22)	436,838	436,838	6
7	TOTAL OVERHEAD (from Worksheet M-2, line 16)	589,399	589,399	7
8	RATIO OF PNEUMOCOCCAL AND INFUENZA VACCINE DIRECT COST TO TOTAL DIRECT COST (line 5 divided by line 6)	0.001337	0.002076	8
9	OVERHEAD COST - PNEUMOCOCCAL AND INFLUENZA VACCINE (line 7 x line 8)	788	1,224	9
10	TOTAL PNEUMOCOCCAL AND INFLUENZA VACCINE COSTS AND THEIR ADMINISTRATION COSTS (sum of lines 5 and 9)	1,372	2,131	10
11	TOTAL NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS (from your records)	15	37	11
12	COST PER PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTION (line 10/line 11)	91.47	57.59	12
13	NUMBER OF PNEUMOCOCCAL AND INFLUENZA VACCINE INJECTIONS ADMINISTERED TO PROGRAM BENEFICIARIES	15	37	13
14	PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR THEIR ADMINISTRATION COSTS (line 12 x line 13)	1,372	2,131	14
15	TOTAL COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		3,503	15
16	TOTAL PROGRAM COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES AND THEIR ADMINISTRATION COSTS (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		3,503	16

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	--------------------------------	--	---

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: RHC FQHC

1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			66,713	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
			.01		3.01
			.02		3.02
		PROGRAM	.03		3.03
		TO	.04		3.04
		PROVIDER	.05		3.05
			.06		3.06
			.07		3.07
			.08		3.08
			.09		3.09
			.10		3.10
			.50		3.50
			.51	09/24/2013	3.51
		PROVIDER	.52	4,265	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	-4,265	3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. J-3, line 27)			62,448	
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
			.01		5.01
			.02		5.02
		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) BASED ON THE COST REPORT (1)		.01	22,826	6.01
			.02		6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			85,274	
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.

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	Non CMS worksheet CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---	--	---

REPORT 97 - UTILIZATION STATISTICS - HOSPITAL

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON DAYS								
30	ADULTS & PEDIATRICS	63.71		2.30				66.01	30
	UTILIZATION PERCENTAGES BASED ON CHARGES								
50	OPERATING ROOM	11.59	44.25					55.84	50
54	RADIOLOGY-DIAGNOSTIC	5.09	40.15					45.24	54
57	CT SCAN	3.48	41.27					44.75	57
58	MRI	2.36	42.00					44.36	58
60	LABORATORY	7.95	30.67					38.62	60
65	RESPIRATORY THERAPY	34.39	25.74					60.13	65
66	PHYSICAL THERAPY	3.22	37.61					40.83	66
69	ELECTROCARDIOLOGY	3.72	53.30					57.02	69
71	MEDICAL SUPPLIES CHARGED TO PAT	31.07	27.83					58.90	71
72	IMPL. DEV. CHARGED TO PATIENTS	8.31	26.66					34.97	72
73	DRUGS CHARGED TO PATIENTS	22.33	38.03					60.36	73
90	CLINIC	0.27	56.05					56.32	90
91	EMERGENCY	0.05	34.62					34.67	91
92	OBSERVATION BEDS (NON-DISTINCT		53.18					53.18	92
200	TOTAL CHARGES	8.97	35.79					44.76	200

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	Non CMS worksheet CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---	--	---

REPORT 97 - UTILIZATION STATISTICS - SWING-BED SNF / NF

	COST CENTERS	TITLE XVIII		TITLE XIX		TITLE V		TOTAL THIRD PARTY UTIL	
		PART A	PART B	INPATIENT	OUTPAT- IENT	INPATIENT	OUTPAT- IENT		
		1	2	3	4	5	6	7	
	UTILIZATION PERCENTAGES BASED ON CHARGES								
54	RADIOLOGY-DIAGNOSTIC	0.79						0.79	54
60	LABORATORY	0.56						0.56	60
65	RESPIRATORY THERAPY	1.27						1.27	65
66	PHYSICAL THERAPY	9.75						9.75	66
69	ELECTROCARDIOLOGY	0.09						0.09	69
71	MEDICAL SUPPLIES CHARGED TO PAT	3.13						3.13	71
73	DRUGS CHARGED TO PATIENTS	3.03						3.03	73
200	TOTAL CHARGES	1.10						1.10	200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	Non CMS worksheet CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	----------------------------------	--	---

REPORT 98 - COST ALLOCATION SUMMARY

	COST CENTERS	DIRECT COSTS		ALLOCATED OVERHEAD		TOTAL COSTS		
		AMOUNT	%	AMOUNT	%	AMOUNT	%	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	1,641,012	7.53	-1,641,012	-15.44			1
2	CAP REL COSTS-MVBLE EQUIP	1,338,042	6.14	-1,338,042	-12.59			2
3	OTHER CAP REL COSTS							3
4	EMPLOYEE BENEFITS DEPARTMENT	1,937,589	8.89	-1,937,589	-18.24			4
5.01	ADMINISTRATIVE & ACCOUNTING	1,053,811	4.84	-1,053,811	-9.92			5.01
5.02	BUSINESS SERVICES	1,191,317	5.47	-1,191,317	-11.21			5.02
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	819,435	3.76	-819,435	-7.71			7
8	LAUNDRY & LINEN SERVICE	47,897	0.22	-47,897	-0.45			8
9	HOUSEKEEPING	194,244	0.89	-194,244	-1.83			9
10	DIETARY	150,042	0.69	-150,042	-1.41			10
11	CAFETERIA	363,591	1.67	-363,591	-3.42			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	102,915	0.47	-102,915	-0.97			13
14	CENTRAL SERVICES & SUPPLY							14
14.01	PURCHASING	107,185	0.49	-107,185	-1.01			14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	PHARMACY	1,299,731	5.97	-1,299,731	-12.23			15
16	MEDICAL RECORDS & LIBRARY	314,122	1.44	-314,122	-2.96			16
17	SOCIAL SERVICE	63,995	0.29	-63,995	-0.60			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	1,920,331	8.81	1,876,130	17.66	3,796,461	17.43	30
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	923,965	4.24	899,455	8.47	1,823,420	8.37	50
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	937,684	4.30	776,403	7.31	1,714,087	7.87	54
57	CT SCAN	213,183	0.98	355,140	3.34	568,323	2.61	57
58	MRI	99,319	0.46	484,451	4.56	583,770	2.68	58
60	LABORATORY	1,524,089	7.00	1,367,027	12.87	2,891,116	13.27	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	434,730	2.00	399,053	3.76	833,783	3.83	65
66	PHYSICAL THERAPY	811,610	3.73	389,588	3.67	1,201,198	5.51	66
67	OCCUPATIONAL THERAPY							67
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	47,376	0.22	73,381	0.69	120,757	0.55	69
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	548,428	2.52	164,988	1.55	713,416	3.27	71
72	IMPL. DEV. CHARGED TO PATIENTS	321,502	1.48	28,190	0.27	349,692	1.61	72
73	DRUGS CHARGED TO PATIENTS			1,536,981	14.47	1,536,981	7.05	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
88	RURAL HEALTH CLINIC	665,529	3.05	360,708	3.39	1,026,237	4.71	88
90	CLINIC	162,082	0.74	121,818	1.15	283,900	1.30	90
90.01	SALEM MEDICAL CLINIC							90.01
91	EMERGENCY	1,715,193	7.87	837,461	7.88	2,552,654	11.72	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
	OUTPATIENT SERVICE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	108,209	0.50	72,185	0.68	180,394	0.83	190
192	PHYSICIANS' PRIVATE OFFICES	49,949	0.23	41,234	0.39	91,183	0.42	192
192.0	TEMPORARILY IDLE SPACE			457,607	4.31	457,607	2.10	192.0
1								1
192.0	STH FAM HLTH CRT	677,941	3.11	383,128	3.61	1,061,069	4.87	192.0
2								2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL	21,786,048	100.00			21,786,048	100.00	202

Optimizer Systems, Inc.

WinLASH

Micro System

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	Non CMS worksheet CMS-2552-10	Period : From: 04/01/2013 To: 03/31/2014	Run Date: 08/25/2014 Run Time: 09:06 Version: 2014.03
--	---	--	---

REPORT 99 - APPORTIONMENT OF INPATIENT MEDICARE ANCILLARY SERVICE PPS CAPITAL COSTS

	COST CENTER DESCRIPTION	CAPITAL RELATED COSTS	TOTAL CHARGES	RATIO OF CAPITAL COSTS TO CHARGES	INPATIENT PROGRAM CHARGES	MEDICARE INPATIENT PPS CAPITAL COSTS	
		1	2	3	4	5	

**** THIS PROVIDER IS NOT A PPS HOSPITAL

III. COST TO CHARGE RATIO FOR OUTPATIENT SERVICES

1. TOTAL PROGRAM (Title XVIII) OUTPATIENT COST EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, columns 2, 2.01, 2.02 x column 1 less lines 61, 66-68, 74, 94, 95 & 96)
2. TOTAL PROGRAM (TITLE XVIII) OUTPATIENT CHARGES EXCLUDING SERVICES NOT SUBJECT TO OPPTS. (Worksheet D, Part V, line 202, columns 2, 2.01, & 2.02 less lines 61, 66-68, 74, 94, 95 & 96)
3. RATIO OF COST TO CHARGES (line 1 / line 2)