

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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 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 type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 08/25/2016 Time: 07:20
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SALEM TOWNSHIP HOSPITAL (14-1345) (Provider Name(s) and Number(s)) for the cost reporting period beginning 04/01/2015 and ending 03/31/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII						
		TITLE V	PART A	PART B	HIT	TITLE XIX		
		1	2	3	4	5		
1	HOSPITAL		-227,801	35,830		257,178	1	
2	SUBPROVIDER - IPF						2	
3	SUBPROVIDER - IRF						3	
4	SUBPROVIDER (OTHER)						4	
5	SWING BED - SNF		29,522				5	
6	SWING BED - NF						6	
7	SKILLED NURSING FACILITY						7	
8	NURSING FACILITY						8	
9	HOME HEALTH AGENCY						9	
10	HEALTH CLINIC - RHC			51,836			10	
11	HEALTH CLINIC - FQHC						11	
12	OUTPATIENT REHABILITATION PROVIDER						12	
200	TOTAL		-198,279	87,666		257,178	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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2015	To: 03 / 31 / 2016	20
21	Type of control (see instructions)	12		21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N						37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
		1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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 Nonprovider Settings

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in 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 nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 ÷ column 4)). (see instructions)							
	Program Name	Program Code		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
	1	2		3	4	5	
67							67

Inpatient Psychiatric 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, indicate which program year began during this cost reporting period. (see instructions)				71

Inpatient Rehabilitation Facility PPS

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

Long Term Care Hospital PPS

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

TEFRA Providers

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

Rural Providers

		1	2			
105	Does this hospital qualify as a critical access hospital (CAH)?	Y		105		
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106		
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107		
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108		
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	Y	Y	N	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.				N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	Y			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	224,425			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	Y			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare 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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

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

Multicampus

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

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	N				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)					168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)	N				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)					169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)				N	171

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3

		Y/N	Type	Date	
Financial Data and Reports					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

		Y/N	Y/N	
Approved Educational Activities				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
Bad Debts			
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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
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	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/21/2016	Y	07/21/2016
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	
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	
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	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

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

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.	Y	22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.	Y	24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	Y	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

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

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

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	Y	35

Home Office Costs		Y/N	Date	
36	Are home office costs claimed on the cost report?	N	2	36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

Cost Report Preparer Contact Information			
41	First name: AMBER	Last name: HALSTEAD	Title: SENIOR MANAGER
42	Employer: KERBER, ECK & BRAECKEL, LLP		
43	Phone number: 618-529-1040	E-mail Address: AMBERH@KEBCPA.COM	

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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	9,150	25,992.00		1,083	145	1,591	1
2	HMO and other (see instructions)						83			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						548		548	5
6	Hospital Adults & Peds. Swing Bed NF								40	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,150	25,992.00		1,631	145	2,179	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	9,150	25,992.00		1,631	145	2,179	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					2,039		12,642	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								291	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					305	60	534	1
2	HMO and other (see instructions)					19			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)		181.84			305	60	534	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		12.85						26
27	Total (sum of lines 14-26)		194.69						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

SNF SERVICES

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

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each 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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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)		0.423565	1
---	--	--	----------	---

Medicaid (see instructions for each line)

2	Net revenue from Medicaid		2,203,820	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		1,117,588	5
6	Medicaid charges		9,527,794	6
7	Medicaid cost (line 1 times line 6)		4,035,640	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.		714,232	8

State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP			9
10	Stand-alone SCHIP charges			10
11	Stand-alone SCHIP cost (line 1 times line 10)			11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.			12

Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)			13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)			14
15	State or local indigent care program cost (line 1 times line 14)			15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.			16

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng 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)		714,232	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	139,159	73,299	212,458
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	58,943	31,047	89,990
22	Partial payment by patients approved for charity care	14,808	10,290	25,098
23	Cost of charity care (line 21 minus line 22)	44,135	20,757	64,892

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)		759,338	26
27	Medicare bad debts for the entire hospital complex (see instructions)		286,400	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		472,938	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		200,320	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		265,212	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		979,444	31

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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		1,118,286	1,118,286	446,101	1,564,387		1,564,387	1
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2		327,747	327,747	272,630	600,377		600,377	1.01
2	00200	Cap Rel Costs-Mvble Equip		627,955	627,955	759,547	1,387,502	-32,593	1,354,909	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	155,757	3,015,542	3,171,299		3,171,299	-86,825	3,084,474	4
5.01	00592	ADMINISTRATIVE & ACCOUNTING	811,675	2,333,506	3,145,181	-728,960	2,416,221	-793,076	1,623,145	5.01
5.02	00591	BUSINESS SERVICES	431,486	567,937	999,423	-3,365	996,058	-39,568	956,490	5.02
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	254,347	632,496	886,843	-3,200	883,643		883,643	7
8	00800	Laundry & Linen Service	32,362	23,128	55,490		55,490		55,490	8
9	00900	Housekeeping	169,705	86,148	255,853		255,853		255,853	9
10	01000	Dietary	265,494	407,988	673,482	-522,949	150,533	-26,153	124,380	10
11	01100	Cafeteria				521,934	521,934	-115,945	405,989	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	19,824	3,583	23,407		23,407		23,407	13
14	01400	Central Services & Supply								14
14.01	01401	PURCHASING	97,621	21,213	118,834	-1,476	117,358		117,358	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	15,977	428,383	444,360	-444,360				14.02
15	01500	Pharmacy	48,396	1,211,391	1,259,787	-5,990	1,253,797		1,253,797	15
16	01600	Medical Records & Library	241,697	171,949	413,646		413,646		413,646	16
17	01700	Social Service	57,823	9,604	67,427		67,427		67,427	17
19	01900	Nonphysician Anesthetists				529,868	529,868	-529,868		19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,827,449	565,452	2,392,901	174,975	2,567,876	-760,896	1,806,980	30
		ANCLLARY SERVICE COST CENTERS								
50	05000	Operating Room	559,852	535,425	1,095,277	-152,775	942,502	-86,000	856,502	50
53	05300	Anesthesiology		553,377	553,377	-553,377				53
54	05400	Radiology-Diagnostic	588,024	453,039	1,041,063	-48,160	992,903	-6,460	986,443	54
57	05700	CT Scan	83,441	68,151	151,592		151,592		151,592	57
58	05800	MRI	102,205	353,912	456,117	-337,800	118,317		118,317	58
60	06000	Laboratory	584,928	1,216,500	1,801,428	-198,557	1,602,871		1,602,871	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	320,554	213,978	534,532	-8,480	526,052	-64,264	461,788	65
66	06600	Physical Therapy		691,423	691,423		691,423	-24,553	666,870	66
69	06900	Electrocardiology	68,599	32,226	100,825	-253	100,572	-50,518	50,054	69
71	07100	Medical Supplies Charged to Patients				444,360	444,360		444,360	71
72	07200	Impl. Dev. Charged to Patients		377,453	377,453		377,453		377,453	72
73	07300	Drugs Charged to Patients								73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	1,115,905	285,014	1,400,919	-184,141	1,216,778		1,216,778	88
90	09000	Clinic	201,887	26,439	228,326	-6,104	222,222		222,222	90
90.01	09001	SALEM MEDICAL CLINIC								90.01
91	09100	Emergency	1,005,061	2,104,088	3,109,149	-55,185	3,053,964	-1,162,697	1,891,267	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	9,060,069	18,463,333	27,523,402	-105,717	27,417,685	-3,779,416	23,638,269	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	50,189	51,985	102,174		102,174		102,174	190
192	19200	Physicians' Private Offices	57,623	18,942	76,565		76,565		76,565	192
192.01	19201	TEMPORARILY IDLE SPACE								192.01
192.02	19202	STH FAM HLTH CRT	973,845	305,903	1,279,748	105,717	1,385,465		1,385,465	192.02
200		TOTAL (sum of lines 118-199)	10,141,726	18,840,163	28,981,889		28,981,889	-3,779,416	25,202,473	200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
1	TO RECLASS CAFETERIA COST	A	Cafeteria	11	205,752	316,182	1
500	Total reclassifications				205,752	316,182	500
	Code Letter - A						
1	TO RECLASSIFY SUPPLY COST	B	Medical Supplies Charged to P	71	15,977	428,383	1
500	Total reclassifications				15,977	428,383	500
	Code Letter - B						
1	TO RECLASS RENTALS	C	Cap Rel Costs-Mvble Equip	2		750,175	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
500	Total reclassifications					750,175	500
	Code Letter - C						
1	TO RECLASS CRNA COST	D	Nonphysician Anesthetists	19		529,868	1
500	Total reclassifications					529,868	500
	Code Letter - D						
1	TO RECLASS REMAINING ANESTHESIA SUPP	E	Operating Room	50		23,509	1
500	Total reclassifications					23,509	500
	Code Letter - E						
1	TO RECLASS INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		356,129	1
2			NEW CAP-REL CSTS-BLDGS & FIX	1.01		272,630	2
3			Cap Rel Costs-Mvble Equip	2		9,372	3
500	Total reclassifications					638,131	500
	Code Letter - F						
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G	Rural Health Clinic	88		32,099	1
500	Total reclassifications					32,099	500
	Code Letter - G						
1	TO RECLASS OTHER CAPITAL COSTS	H	Cap Rel Costs-Bldg & Fixt	1		89,972	1
500	Total reclassifications					89,972	500
	Code Letter - H						
1	RECLASS THE REF LAB TO FHCC	J	STH FAM HLTH CRT	192.02		111,915	1
500	Total reclassifications					111,915	500
	Code Letter - J						
1	RECLASS HOSPITALIST SERVICES	K	Adults & Pediatrics	30	191,302	21,602	1
500	Total reclassifications				191,302	21,602	500
	Code Letter - K						
	GRAND TOTAL (Increases)				413,031	2,941,836	

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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	205,752	316,182	1	
500	Total reclassifications				205,752	316,182	500	
	Code letter - A							
1	TO RECLASSIFY SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	14.02	15,977	428,383	1	
500	Total reclassifications				15,977	428,383	500	
	Code letter - B							
1	TO RECLASS RENTALS	C	ADMINISTRATIVE & ACCOUNTING	5.01		857	10	
2			BUSINESS SERVICES	5.02		3,365	2	
3			Operation of Plant	7		3,200	3	
4			Dietary	10		1,015	4	
5			PURCHASING	14.01		1,476	5	
6			Pharmacy	15		5,990	6	
7			Adults & Pediatrics	30		37,929	7	
8			Operating Room	50		176,284	8	
9			Radiology-Diagnostic	54		48,160	9	
10			MRI	58		337,800	10	
11			Laboratory	60		86,642	11	
12			Respiratory Therapy	65		8,480	12	
13			Electrocardiology	69		253	13	
14			Rural Health Clinic	88		3,336	14	
15			Clinic	90		6,104	15	
16			Emergency	91		23,086	16	
17			STH FAM HLTH CRT	192.02		6,198	17	
500	Total reclassifications					750,175	500	
	Code letter - C							
1	TO RECLASS CRNA COST	D	Anesthesiology	53		529,868	1	
500	Total reclassifications					529,868	500	
	Code letter - D							
1	TO RECLASS REMAINING ANESTHESIA SUPP	E	Anesthesiology	53		23,509	1	
500	Total reclassifications					23,509	500	
	Code letter - E							
1	TO RECLASS INTEREST EXPENSE	F	ADMINISTRATIVE & ACCOUNTING	5.01		638,131	14	
2							14	
3							14	
500	Total reclassifications					638,131	500	
	Code letter - F							
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G	Emergency	91		32,099	1	
500	Total reclassifications					32,099	500	
	Code letter - G							
1	TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	5.01		89,972	14	
500	Total reclassifications					89,972	500	
	Code letter - H							
1	RECLASS THE REF LAB TO FHCC	J	Laboratory	60		111,915	1	
500	Total reclassifications					111,915	500	
	Code letter - J							
1	RECLASS HOSPITALIST SERVICES	K	Rural Health Clinic	88	191,302	21,602	1	
500	Total reclassifications				191,302	21,602	500	
	Code letter - K							
	GRAND TOTAL (Decreases)				413,031	2,941,836		

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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	4	5	6	7	
1	Land	134,755					134,755		1
2	Land Improvements	1,160,946	36,982		36,982	26,807	1,171,121		2
3	Buildings and Fixtures	36,896,734	13,495,686		13,495,686	15,289,044	35,103,376		3
4	Building Improvements								4
5	Fixed Equipment	2,101,871	665,705		665,705	21,634	2,745,942		5
6	Movable Equipment	8,865,769	1,525,403		1,525,403	1,023,542	9,367,630		6
7	HIT-designated Assets	1,079,269					1,079,269		7
8	Subtotal (sum of lines 1-7)	50,239,344	15,723,776		15,723,776	16,361,027	49,602,093		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	50,239,344	15,723,776		15,723,776	16,361,027	49,602,093		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 instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	1,118,286						1,118,286	1	
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	327,747						327,747	1.01	
2	Cap Rel Costs-Mvble Equip	627,955						627,955	2	
3	Total (sum of lines 1-2)	2,073,988						2,073,988	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				Total (sum of cols. 5 through 7)	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs			
*		1	2	3	4	5	6	7	8		
1	Cap Rel Costs-Bldg & Fi				0.000000					1	
1.01	NEW CAP-REL CSTS-BLDGS				0.000000					1.01	
2	Cap Rel Costs-Mvble Equ				0.000000					2	
3	Total (sum of lines 1-2)				0.000000					3	

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	1,118,286					446,101	1,564,387	1	
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	327,747					272,630	600,377	1.01	
2	Cap Rel Costs-Mvble Equip	627,955	750,175				-23,221	1,354,909	2	
3	Total (sum of lines 1-2)	2,073,988	750,175				695,510	3,519,673	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.)

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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.
				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	-5,402	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	-729	BUSINESS SERVICES	5.02		7
8	Television and radio service (chapter 21)	A	-2,542	ADMINISTRATIVE & ACCOUNTING	5.01		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-2,130,835				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	-115,945	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts						18
19	Nursing school (tuition,fees,books,etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist		-529,868	Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	B	-24,619	Cap Rel Costs-Mvble Equip	2	14	32
33	TELEPHONE	A	-1,376	BUSINESS SERVICES	5.02		33
34	DIETARY REVENUE	B	-26,153	Dietary	10		34
35	BUS OFFICE COSTS ASSOC W/ PHYS CHG	A	-37,463	BUSINESS SERVICES	5.02		35
36							36
37	PHYSICIAN RECRUITMENT	A	-58,227	ADMINISTRATIVE & ACCOUNTING	5.01		37
38	OTHER REVENUE	B	-3,424	ADMINISTRATIVE & ACCOUNTING	5.01		38
39	LOBBYING PORTION OF DUES	A	-15,612	ADMINISTRATIVE & ACCOUNTING	5.01		39
40	MARKETING	A	-86,825	Employee Benefits Department	4		40
41	OTHER REVENUE	B	-1,894	ADMINISTRATIVE & ACCOUNTING	5.01		41
42	SPOUSE MEAL COST	A	-700	ADMINISTRATIVE & ACCOUNTING	5.01		42
43	GOODWILL AMORTIZATION- PHY. CLINIC	A	-333,510	ADMINISTRATIVE & ACCOUNTING	5.01		43
44	IMPAIRED ASSETS	A	-7,974	Cap Rel Costs-Mvble Equip	2	14	44
45	LEGAL FEES	A	-371,265	ADMINISTRATIVE & ACCOUNTING	5.01		45
46	ATHLETIC TRAINER	A	-24,553	Physical Therapy	66		46
47	ADVERTISING	A	-500	ADMINISTRATIVE & ACCOUNTING	5.01		47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-3,779,416				50

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

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

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:

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	50	Operating Room OR	86,000	86,000						1
2	60	Laboratory LABORATORY	68,758		68,758					2
3	65	Respiratory Therapy RESPIRATORY THE	770	770						3
4	65	Respiratory Therapy RESPIRATORY THE	63,494	63,494						4
5	69	Electrocardiology ELECTROCARDIOLO	50,518	50,518						5
6	91	Emergency EMERGENCY	1,887,188	1,162,697	724,491					6
7	30	Adults & Pediatrics HOSPITALIST	760,896	760,896						7
8	54	Radiology-Diagnostic ECHOCARDIOLOGY	6,460	6,460						8
9	53	Anesthesiology ANESTHESIOLOGY	24,000		24,000					9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	2,948,084	2,130,835	817,249					200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	50	Operating Room OR							86,000	1
2	60	Laboratory LABORATORY								2
3	65	Respiratory Therapy RESPIRATORY THE							770	3
4	65	Respiratory Therapy RESPIRATORY THE							63,494	4
5	69	Electrocardiology ELECTROCARDIOLO							50,518	5
6	91	Emergency EMERGENCY							1,162,697	6
7	30	Adults & Pediatrics HOSPITALIST							760,896	7
8	54	Radiology-Diagnostic ECHOCARDIOLOGY							6,460	8
9	53	Anesthesiology ANESTHESIOLOGY								9
										10
										11
										12
										13
										14
										15
										16
										17
										18
										19
										20
200		TOTAL							2,130,835	200

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					16	1
2	Line 1 multiplied by 15 hours per week					240	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 visit(s)) (see instructions)						6
7	Standard travel expense rate					5.40	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		1,139.75				9
10	AHSEA (see instructions)		76.01				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	38.01	38.01				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)					86,632	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)					86,632	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)					86,632	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)					86,632	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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

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

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)		86,632	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)		86,632	63
64	Total cost of outside supplier services (from provider records)		56,059	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)			65

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					16	1
2	Line 1 multiplied by 15 hours per week					240	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 visit(s)) (see instructions)						6
7	Standard travel expense rate					5.40	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked	810.00	3,925.75		4,380.68		9
10	AHSEA (see instructions)	47.27	80.20		60.15		10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	40.10	40.10				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)					38,289	14
15	Therapists (column 2, line 9 times column 2, line 10)					314,845	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)					353,134	17
18	Aides (column 4, line 9 times column 4, line 10)					263,498	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)					616,632	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)					616,632	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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

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

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)		616,632	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)		616,632	63
64	Total cost of outside supplier services (from provider records)		570,117	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)			65

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

Check applicable box: Occupational Physical Respiratory Speech Pathology

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					5	1
2	Line 1 multiplied by 15 hours per week					75	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 visit(s)) (see instructions)						6
7	Standard travel expense rate					5.40	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		14.50				9
10	AHSEA (see instructions)		73.04				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	36.52	36.52				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)					1,059	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)					1,059	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)					1,059	20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.						
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)					73.03	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)					5,477	22
23	Total salary equivalency (see instructions)					5,477	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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

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

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)		5,477	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)		5,477	63
64	Total cost of outside supplier services (from provider records)		710	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)			65

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES		CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL (cols.0-4)	
		0	1	1.01	2	4	4A	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	1,564,387	1,564,387					1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	600,377		600,377				1.01
2	Cap Rel Costs-Mvble Equip	1,354,909			1,354,909			2
4	Employee Benefits Department	3,084,474	12,281		1,539	3,098,294		4
5.01	ADMINISTRATIVE & ACCOUNTING	1,623,145	311,946	34,252	10,898	251,834	2,232,075	5.01
5.02	BUSINESS SERVICES	956,490	87,607	705	165,092	133,875	1,343,769	5.02
6	Maintenance & Repairs							6
7	Operation of Plant	883,643	282,110	29,072	20,500	78,915	1,294,240	7
8	Laundry & Linen Service	55,490	12,357			10,041	77,888	8
9	Housekeeping	255,853	10,266		32	52,654	318,805	9
10	Dietary	124,380	32,530		2,437	18,536	177,883	10
11	Cafeteria	405,989	17,763			63,838	487,590	11
12	Maintenance of Personnel							12
13	Nursing Administration	23,407	5,086		749	6,151	35,393	13
14	Central Services & Supply							14
14.01	PURCHASING	117,358	18,460		1,910	30,288	168,016	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy	1,253,797		20,139	6,323	15,016	1,295,275	15
16	Medical Records & Library	413,646	17,499		14,820	74,990	520,955	16
17	Social Service	67,427				17,940	85,367	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	1,806,980	48,503	284,409	103,895	626,345	2,870,132	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	856,502	116,107		237,192	173,702	1,383,503	50
53	Anesthesiology							53
54	Radiology-Diagnostic	986,443	102,582		159,854	182,443	1,431,322	54
57	CT Scan	151,592	8,721		72,381	25,889	258,583	57
58	MRI	118,317	6,348		332,109	31,711	488,485	58
60	Laboratory	1,602,871	67,905		104,272	181,483	1,956,531	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	461,788	34,489	19,593	23,074	99,457	638,401	65
66	Physical Therapy	666,870	96,121		4,473		767,464	66
69	Electrocardiology	50,054		7,823	7,280	21,284	86,441	69
71	Medical Supplies Charged to Patients	444,360		11,717	407	4,957	461,441	71
72	Impl. Dev. Charged to Patients	377,453					377,453	72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,216,778		84,625	10,564	286,872	1,598,839	88
90	Clinic	222,222	43,549	6,449	11,618	62,638	346,476	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	1,891,267	79,979		40,972	311,835	2,324,053	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)	23,638,269	1,412,209	498,784	1,332,391	2,762,694	23,026,380	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	102,174	15,992		2,905	15,572	136,643	190
192	Physicians' Private Offices	76,565		101,593	6,480	17,878	202,516	192
192.01	TEMPORARILY IDLE SPACE		67,923				67,923	192.01
192.02	STH FAM HLTH CRT	1,385,465	68,263		13,133	302,150	1,769,011	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,202,473	1,564,387	600,377	1,354,909	3,098,294	25,202,473	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ADMINISTRATIVE & ACCOUNTING	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.01	5.02	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING	2,232,075						5.01
5.02	BUSINESS SERVICES	130,577	1,474,346					5.02
6	Maintenance & Repairs							6
7	Operation of Plant	125,764		1,420,004				7
8	Laundry & Linen Service	7,569		12,153	97,610			8
9	Housekeeping	30,979		10,096	10,797	370,677		9
10	Dietary	17,285		31,993	838	14,841	242,840	10
11	Cafeteria	47,380		17,469				11
12	Maintenance of Personnel							12
13	Nursing Administration	3,439		5,002				13
14	Central Services & Supply							14
14.01	PURCHASING	16,326		18,155				14.01
14.02	CENTRAL SERVICES & SUPPLY					7,593		14.02
15	Pharmacy	125,864		21,174		4,487		15
16	Medical Records & Library	50,622		17,210		3,106		16
17	Social Service	8,295						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	278,893	96,368	346,740	36,894	86,286	242,840	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	134,438	97,021	114,190	13,655	38,655		50
53	Anesthesiology							53
54	Radiology-Diagnostic	139,084	149,830	100,889	14,265	31,407		54
57	CT Scan	25,127	248,206	8,577		5,522		57
58	MRI	47,467	56,249	6,243				58
60	Laboratory	190,120	338,633	66,784		26,921		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	62,035	77,718	54,520		14,841		65
66	Physical Therapy	74,576	83,155	94,535	3,719	12,770		66
69	Electrocardiology	8,400	23,945	8,225		3,451		69
71	Medical Supplies Charged to Patients	44,839	34,827	12,319				71
72	Impl. Dev. Charged to Patients	36,678	10,862					72
73	Drugs Charged to Patients		75,413					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	155,362	44,431	88,977		33,478		88
90	Clinic	33,668	11,188	49,611				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	225,833	126,500	78,659	17,442	46,248		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)	2,020,620	1,474,346	1,163,521	97,610	329,606	242,840	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	13,278		15,728		4,832		190
192	Physicians' Private Offices	19,679		106,817		36,239		192
192.01	TEMPORARILY IDLE SPACE	6,600		66,802				192.01
192.02	STH FAM HLTH CRT	171,898		67,136				192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,232,075	1,474,346	1,420,004	97,610	370,677	242,840	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14.01	14.02	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	552,439						11
12	Maintenance of Personnel							12
13	Nursing Administration	2,045	45,879					13
14	Central Services & Supply							14
14.01	PURCHASING	8,018		210,515				14.01
14.02	CENTRAL SERVICES & SUPPLY			275	7,868			14.02
15	Pharmacy	6,495		483		1,453,778		15
16	Medical Records & Library	28,704		777			621,374	16
17	Social Service	4,049						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	127,205	20,266	12,093			99,350	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	41,172	6,570	28,580			59,842	50
53	Anesthesiology							53
54	Radiology-Diagnostic	45,582		16,141			9,005	54
57	CT Scan	5,773		5,559				57
58	MRI	7,737		1,560				58
60	Laboratory	57,729		117,512			193,183	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	30,388		3,330			38,636	65
66	Physical Therapy			1,806		4	49,094	66
69	Electrocardiology			609			17,720	69
71	Medical Supplies Charged to Patients	2,526				3,954		71
72	Impl. Dev. Charged to Patients					3,510		72
73	Drugs Charged to Patients					1,453,778		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	52,398	8,296	3,082			29,340	88
90	Clinic	14,152		1,004				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	67,151	10,747	10,138			125,204	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)	501,124	45,879	202,949	7,468	1,453,778	621,374	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	7,296		986	400			190
192	Physicians' Private Offices	5,412		2,033				192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	38,607		4,547				192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	552,439	45,879	210,515	7,868	1,453,778	621,374	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	BUSINESS SERVICES						5.02
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY						14.02
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service	97,711					17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	97,711	4,314,778		4,314,778		30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		1,917,626		1,917,626		50
53	Anesthesiology						53
54	Radiology-Diagnostic		1,937,525		1,937,525		54
57	CT Scan		557,347		557,347		57
58	MRI		607,741		607,741		58
60	Laboratory		2,947,413		2,947,413		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		919,869		919,869		65
66	Physical Therapy		1,087,123		1,087,123		66
69	Electrocardiology		148,791		148,791		69
71	Medical Supplies Charged to Patients		559,906		559,906		71
72	Impl. Dev. Charged to Patients		428,503		428,503		72
73	Drugs Charged to Patients		1,529,191		1,529,191		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		2,014,203		2,014,203		88
90	Clinic		456,099		456,099		90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency		3,031,975		3,031,975		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)	97,711	22,458,090		22,458,090		118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		179,163		179,163		190
192	Physicians' Private Offices		372,696		372,696		192
192.01	TEMPORARILY IDLE SPACE		141,325		141,325		192.01
192.02	STH FAM HLTH CRT		2,051,199		2,051,199		192.02
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	97,711	25,202,473		25,202,473		202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES		CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	
		0	1	1.01	2	2A	4	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		12,281		1,539	13,820	13,820	4
5.01	ADMINISTRATIVE & ACCOUNTING		311,946	34,252	10,898	357,096	1,123	5.01
5.02	BUSINESS SERVICES		87,607	705	165,092	253,404	597	5.02
6	Maintenance & Repairs							6
7	Operation of Plant		282,110	29,072	20,500	331,682	352	7
8	Laundry & Linen Service		12,357			12,357	45	8
9	Housekeeping		10,266		32	10,298	235	9
10	Dietary		32,530		2,437	34,967	83	10
11	Cafeteria		17,763			17,763	285	11
12	Maintenance of Personnel							12
13	Nursing Administration		5,086		749	5,835	27	13
14	Central Services & Supply							14
14.01	PURCHASING		18,460		1,910	20,370	135	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy			20,139	6,323	26,462	67	15
16	Medical Records & Library		17,499		14,820	32,319	335	16
17	Social Service						80	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		48,503	284,409	103,895	436,807	2,793	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		116,107		237,192	353,299	775	50
53	Anesthesiology							53
54	Radiology-Diagnostic		102,582		159,854	262,436	814	54
57	CT Scan		8,721		72,381	81,102	115	57
58	MRI		6,348		332,109	338,457	141	58
60	Laboratory		67,905		104,272	172,177	810	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		34,489	19,593	23,074	77,156	444	65
66	Physical Therapy		96,121		4,473	100,594		66
69	Electrocardiology			7,823	7,280	15,103	95	69
71	Medical Supplies Charged to Patients			11,717	407	12,124	22	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			84,625	10,564	95,189	1,280	88
90	Clinic		43,549	6,449	11,618	61,616	279	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency		79,979		40,972	120,951	1,391	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)		1,412,209	498,784	1,332,391	3,243,384	12,323	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		15,992		2,905	18,897	69	190
192	Physicians' Private Offices			101,593	6,480	108,073	80	192
192.01	TEMPORARILY IDLE SPACE		67,923			67,923		192.01
192.02	STH FAM HLTH CRT		68,263		13,133	81,396	1,348	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,564,387	600,377	1,354,909	3,519,673	13,820	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	ADMINISTRATIVE & ACCOUNTING	BUSINESS SERVICES	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	
		5.01	5.02	7	8	9	10	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING	358,219						5.01
5.02	BUSINESS SERVICES	20,956	274,957					5.02
6	Maintenance & Repairs							6
7	Operation of Plant	20,184		352,218				7
8	Laundry & Linen Service	1,215		3,014	16,631			8
9	Housekeeping	4,972		2,504	1,840	19,849		9
10	Dietary	2,774		7,936	143	795	46,698	10
11	Cafeteria	7,604		4,333				11
12	Maintenance of Personnel							12
13	Nursing Administration	552		1,241				13
14	Central Services & Supply							14
14.01	PURCHASING	2,620		4,503				14.01
14.02	CENTRAL SERVICES & SUPPLY					407		14.02
15	Pharmacy	20,200		5,252		240		15
16	Medical Records & Library	8,124		4,269		166		16
17	Social Service	1,331						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	44,755	17,973	86,006	6,284	4,617	46,698	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	21,576	18,094	28,324	2,327	2,070		50
53	Anesthesiology							53
54	Radiology-Diagnostic	22,321	27,943	25,025	2,431	1,682		54
57	CT Scan	4,033	46,290	2,127		296		57
58	MRI	7,618	10,491	1,549				58
60	Laboratory	30,512	63,147	16,565		1,442		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,956	14,494	13,523		795		65
66	Physical Therapy	11,969	15,508	23,448	634	684		66
69	Electrocardiology	1,348	4,466	2,040		185		69
71	Medical Supplies Charged to Patients	7,196	6,495	3,056				71
72	Impl. Dev. Charged to Patients	5,886	2,026					72
73	Drugs Charged to Patients		14,065					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	24,934	8,286	22,070		1,793		88
90	Clinic	5,403	2,087	12,305				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	36,244	23,592	19,510	2,972	2,477		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)	324,283	274,957	288,600	16,631	17,649	46,698	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,131		3,901		259		190
192	Physicians' Private Offices	3,158		26,495		1,941		192
192.01	TEMPORARILY IDLE SPACE	1,059		16,570				192.01
192.02	STH FAM HLTH CRT	27,588		16,652				192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	358,219	274,957	352,218	16,631	19,849	46,698	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINISTRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14.01	14.02	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	29,985						11
12	Maintenance of Personnel							12
13	Nursing Administration	111	7,766					13
14	Central Services & Supply							14
14.01	PURCHASING	435		28,063				14.01
14.02	CENTRAL SERVICES & SUPPLY			37	444			14.02
15	Pharmacy	353		64		52,638		15
16	Medical Records & Library	1,558		104			46,875	16
17	Social Service	220						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	6,905	3,431	1,612			7,495	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,235	1,112	3,810			4,514	50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,474		2,152			679	54
57	CT Scan	313		741				57
58	MRI	420		208				58
60	Laboratory	3,133		15,665			14,573	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,649		444			2,915	65
66	Physical Therapy			241			3,704	66
69	Electrocardiology			81			1,337	69
71	Medical Supplies Charged to Patients	137			223			71
72	Impl. Dev. Charged to Patients				198			72
73	Drugs Charged to Patients					52,638		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	2,844	1,404	411			2,213	88
90	Clinic	768		134				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	3,645	1,819	1,351			9,445	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)	27,200	7,766	27,055	421	52,638	46,875	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	396		131	23			190
192	Physicians' Private Offices	294		271				192
192.01	TEMPORAILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	2,095		606				192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	29,985	7,766	28,063	444	52,638	46,875	202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL		
		17	24	25	26		
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	BUSINESS SERVICES						5.02
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY						14.02
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service	1,631					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	1,631	667,007		667,007		30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room		438,136		438,136		50
53	Anesthesiology						53
54	Radiology-Diagnostic		347,957		347,957		54
57	CT Scan		135,017		135,017		57
58	MRI		358,884		358,884		58
60	Laboratory		318,024		318,024		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy		121,376		121,376		65
66	Physical Therapy		156,782		156,782		66
69	Electrocardiology		24,655		24,655		69
71	Medical Supplies Charged to Patients		29,253		29,253		71
72	Impl. Dev. Charged to Patients		8,110		8,110		72
73	Drugs Charged to Patients		66,703		66,703		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		160,424		160,424		88
90	Clinic		82,592		82,592		90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency		223,397		223,397		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)	1,631	3,138,317		3,138,317		118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen		25,807		25,807		190
192	Physicians' Private Offices		140,312		140,312		192
192.01	TEMPORARILY IDLE SPACE		85,552		85,552		192.01
192.02	STH FAM HLTH CRT		129,685		129,685		192.02
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	1,631	3,519,673		3,519,673		202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECONCILIATION	ADMINISTRATIVE & ACCOUNTING ACCUM COST	
		1	1.01	2	4	5A.01	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	83,052						1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2		34,075					1.01
2	Cap Rel Costs-Mvble Equip			1,378,130				2
4	Employee Benefits Department	652		1,565	9,985,969			4
5.01	ADMINISTRATIVE & ACCOUNTING	16,561	1,944	11,085	811,675	-2,232,075	22,970,398	5.01
5.02	BUSINESS SERVICES	4,651	40	167,921	431,486		1,343,769	5.02
6	Maintenance & Repairs							6
7	Operation of Plant	14,977	1,650	20,851	254,347		1,294,240	7
8	Laundry & Linen Service	656			32,362		77,888	8
9	Housekeeping	545		33	169,705		318,805	9
10	Dietary	1,727		2,479	59,742		177,883	10
11	Cafeteria	943			205,752		487,590	11
12	Maintenance of Personnel							12
13	Nursing Administration	270		762	19,824		35,393	13
14	Central Services & Supply							14
14.01	PURCHASING	980		1,943	97,621		168,016	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy		1,143	6,431	48,396		1,295,275	15
16	Medical Records & Library	929		15,074	241,697		520,955	16
17	Social Service				57,823		85,367	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	2,575	16,142	105,676	2,018,751		2,870,132	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,164		241,257	559,852		1,383,503	50
53	Anesthesiology							53
54	Radiology-Diagnostic	5,446		162,594	588,024		1,431,322	54
57	CT Scan	463		73,622	83,441		258,583	57
58	MRI	337		337,800	102,205		488,485	58
60	Laboratory	3,605		106,059	584,928		1,956,531	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,831	1,112	23,469	320,554		638,401	65
66	Physical Therapy	5,103		4,550			767,464	66
69	Electrocardiology		444	7,405	68,599		86,441	69
71	Medical Supplies Charged to Patients		665	414	15,977		461,441	71
72	Impl. Dev. Charged to Patients						377,453	72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		4,803	10,745	924,603		1,598,839	88
90	Clinic	2,312	366	11,817	201,887		346,476	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	4,246		41,674	1,005,061		2,324,053	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)	74,973	28,309	1,355,226	8,904,312	-2,232,075	20,794,305	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	849		2,955	50,189		136,643	190
192	Physicians' Private Offices		5,766	6,591	57,623		202,516	192
192.01	TEMPORARILY IDLE SPACE	3,606					67,923	192.01
192.02	STH FAM HLTH CRT	3,624		13,358	973,845		1,769,011	192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,564,387	600,377	1,354,909	3,098,294		2,232,075	202
203	Unit Cost Multiplier (Wkst. B, Part I)	18.836235	17.619281	0.983150	0.310265		0.097172	203
204	Cost to be allocated (Per Wkst. B, Part II)				13,820		358,219	204
205	Unit Cost Multiplier (Wkst. B, Part II)				0.001384		0.015595	205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	BUSINESS S	OPERATION	LAUNDRY	HOUSE-	DIETARY	CAFETERIA	
		ERVICES	OF PLANT	& LINEN	KEEPING			
		GROSS CHAR	SQUARE	SERVICE	HOURS OF	MEALS	MEALS	
		GES	FEET	POUNDS OF	SERVICE	SERVED	SERVED	
		5.02	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES	53,021,559						5.02
6	Maintenance & Repairs							6
7	Operation of Plant		76,652					7
8	Laundry & Linen Service		656	17,113				8
9	Housekeeping		545	1,893	1,074			9
10	Dietary		1,727	147	43	5,103		10
11	Cafeteria		943				13,780	11
12	Maintenance of Personnel							12
13	Nursing Administration		270				51	13
14	Central Services & Supply							14
14.01	PURCHASING		980				200	14.01
14.02	CENTRAL SERVICES & SUPPLY				22			14.02
15	Pharmacy		1,143		13		162	15
16	Medical Records & Library		929		9		716	16
17	Social Service						101	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	3,465,591	18,717	6,468	250	5,103	3,173	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,489,096	6,164	2,394	112		1,027	50
53	Anesthesiology							53
54	Radiology-Diagnostic	5,388,219	5,446	2,501	91		1,137	54
57	CT Scan	8,926,040	463		16		144	57
58	MRI	2,022,853	337				193	58
60	Laboratory	12,178,807	3,605		78		1,440	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,794,895	2,943		43		758	65
66	Physical Therapy	2,990,439	5,103	652	37			66
69	Electrocardiology	861,106	444		10			69
71	Medical Supplies Charged to Patients	1,252,445	665				63	71
72	Impl. Dev. Charged to Patients	390,636						72
73	Drugs Charged to Patients	2,712,032						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	1,597,824	4,803		97		1,307	88
90	Clinic	402,350	2,678				353	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	4,549,226	4,246	3,058	134		1,675	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)	53,021,559	62,807	17,113	955	5,103	12,500	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		849		14		182	190
192	Physicians' Private Offices		5,766		105		135	192
192.01	TEMPORARILY IDLE SPACE		3,606					192.01
192.02	STH FAM HLTH CRT		3,624				963	192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,474,346	1,420,004	97,610	370,677	242,840	552,439	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.027807	18.525335	5.703851	345.136872	47.587694	40.089913	203
204	Cost to be allocated (Per Wkst. B, Part II)	274,957	352,218	16,631	19,849	46,698	29,985	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.005186	4.595027	0.971834	18.481378	9.151088	2.175980	205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS-TRATION DIRECT NRSING HRS	PURCHASING COSTED REQUIS.	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	
		13	14.01	14.02	15	16	17	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration	149,090						13
14	Central Services & Supply							14
14.01	PURCHASING		1,143,568					14.01
14.02	CENTRAL SERVICES & SUPPLY		1,493	846,122				14.02
15	Pharmacy		2,623		1,000			15
16	Medical Records & Library		4,222			2,139		16
17	Social Service						2,179	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	65,855	65,692			342	2,179	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	21,350	155,252			206		50
53	Anesthesiology							53
54	Radiology-Diagnostic		87,683			31		54
57	CT Scan		30,197					57
58	MRI		8,474					58
60	Laboratory		638,359			665		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,090			133		65
66	Physical Therapy		9,809	429		169		66
69	Electrocardiology		3,310			61		69
71	Medical Supplies Charged to Patients			425,185				71
72	Impl. Dev. Charged to Patients			377,453				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	26,960	16,740			101		88
90	Clinic		5,454					90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	34,925	55,072			431		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)	149,090	1,102,470	803,067	1,000	2,139	2,179	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		5,355	43,055				190
192	Physicians' Private Offices		11,045					192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		24,698					192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	45,879	210,515	7,868	1,453,778	621,374	97,711	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.307727	0.184086	0.009299	1,453.778000	290.497429	44.842129	203
204	Cost to be allocated (Per Wkst. B, Part II)	7,766	28,063	444	52,638	46,875	1,631	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.052089	0.024540	0.000525	52.638000	21.914446	0.748508	205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

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

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
14.01	PURCHASING							14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy							15
16	Medical Records & Library							16
17	Social Service							17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics							30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)							118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT							192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)							202
203	Unit Cost Multiplier (Wkst. B, Part I)							203
204	Cost to be allocated (Per Wkst. B, Part II)							204
205	Unit Cost Multiplier (Wkst. B, Part II)							205

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS				
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics	4,314,778		4,314,778		30
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	1,917,626		1,917,626		50
53	Anesthesiology					53
54	Radiology-Diagnostic	1,937,525		1,937,525		54
57	CT Scan	557,347		557,347		57
58	MRI	607,741		607,741		58
60	Laboratory	2,947,413		2,947,413		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	919,869		919,869		65
66	Physical Therapy	1,087,123		1,087,123		66
69	Electrocardiology	148,791		148,791		69
71	Medical Supplies Charged to Patients	559,906		559,906		71
72	Impl. Dev. Charged to Patients	428,503		428,503		72
73	Drugs Charged to Patients	1,529,191		1,529,191		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	2,014,203		2,014,203		88
90	Clinic	456,099		456,099		90
90.01	SALEM MEDICAL CLINIC					90.01
91	Emergency	3,031,975		3,031,975		91
92	Observation Beds (Non-Distinct Part)	516,129		516,129		92
	OTHER REIMBURSABLE COST CENTERS					
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
200	Subtotal (sum of lines 30 thru 199)	22,974,219		22,974,219		200
201	Less Observation Beds	516,129		516,129		201
202	Total (line 200 minus line 201)	22,458,090		22,458,090		202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

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 SERVICE COST CENTERS							
30	Adults & Pediatrics	3,148,598		3,148,598				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	298,964	3,190,132	3,489,096	0.549605			50
53	Anesthesiology							53
54	Radiology-Diagnostic	309,228	5,078,991	5,388,219	0.359585			54
57	CT Scan	389,926	8,536,114	8,926,040	0.062441			57
58	MRI	52,708	1,970,145	2,022,853	0.300438			58
60	Laboratory	915,047	11,263,760	12,178,807	0.242012			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	951,774	1,843,121	2,794,895	0.329125			65
66	Physical Therapy	382,650	2,607,789	2,990,439	0.363533			66
69	Electrocardiology	24,663	836,443	861,106	0.172791			69
71	Medical Supplies Charged to Patients	257,391	995,054	1,252,445	0.447050			71
72	Impl. Dev. Charged to Patients	251,279	139,357	390,636	1.096937			72
73	Drugs Charged to Patients	528,848	2,183,184	2,712,032	0.563854			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		1,597,824	1,597,824				88
90	Clinic		402,350	402,350	1.133588			90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	1,702	4,547,524	4,549,226	0.666482			91
92	Observation Beds (Non-Distinct Part)		316,993	316,993	1.628203			92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	7,512,778	45,508,781	53,021,559				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	7,512,778	45,508,781	53,021,559				202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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/IID

(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	0.549605		1,600,960			879,896	50
53	Anesthesiology							53
54	Radiology-Diagnostic	0.359585		2,005,691			721,216	54
57	CT Scan	0.062441		3,376,134			210,809	57
58	MRI	0.300438		692,632			208,093	58
60	Laboratory	0.242012		3,903,615			944,722	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.329125		857,859			282,343	65
66	Physical Therapy	0.363533		890,631			323,774	66
69	Electrocardiology	0.172791		441,441			76,277	69
71	Medical Supplies Charged to Pat	0.447050		344,025			153,796	71
72	Impl. Dev. Charged to Patients	1.096937		89,560			98,242	72
73	Drugs Charged to Patients	0.563854		916,179			516,591	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	1.133588		210,210			238,292	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	0.666482		1,454,647			969,496	91
92	Observation Beds (Non-Distinct	1.628203		147,178			239,636	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)			16,930,762			5,863,183	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)			16,930,762			5,863,183	202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-Z345

WORKSHEET D
PART V

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

(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	0.549605							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.359585							54
57	CT Scan	0.062441							57
58	MRI	0.300438							58
60	Laboratory	0.242012							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.329125							65
66	Physical Therapy	0.363533							66
69	Electrocardiology	0.172791							69
71	Medical Supplies Charged to Pat	0.447050							71
72	Impl. Dev. Charged to Patients	1.096937							72
73	Drugs Charged to Patients	0.563854							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.133588							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.666482							91
92	Observation Beds (Non-Distinct)	1.628203							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V
 Applicable Title XVIII, Part A
 Boxes: 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)	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	667,007	150,997	516,010	1,882	274.18	145	39,756	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)	667,007		516,010	1,882		145	39,756	200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

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	438,136	3,489,096	0.125573			50
53	Anesthesiology						53
54	Radiology-Diagnostic	347,957	5,388,219	0.064577			54
57	CT Scan	135,017	8,926,040	0.015126			57
58	MRI	358,884	2,022,853	0.177415			58
60	Laboratory	318,024	12,178,807	0.026113			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	121,376	2,794,895	0.043428			65
66	Physical Therapy	156,782	2,990,439	0.052428			66
69	Electrocardiology	24,655	861,106	0.028632			69
71	Medical Supplies Charged to Pat	29,253	1,252,445	0.023357			71
72	Impl. Dev. Charged to Patients	8,110	390,636	0.020761			72
73	Drugs Charged to Patients	66,703	2,712,032	0.024595			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	160,424	1,597,824	0.100402			88
90	Clinic	82,592	402,350	0.205274			90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	223,397	4,549,226	0.049107			91
92	Observation Beds (Non-Distinct	79,787	316,993	0.251700			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,551,097	49,872,961				200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	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.)
		1	2	3	4	5
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,882		145		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	1,882		145		200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-1345

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
53	Anesthesiology							53
54	Radiology-Diagnostic							54
57	CT Scan							57
58	MRI							58
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART IV

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	3,489,096							50
53	Anesthesiology								53
54	Radiology-Diagnostic	5,388,219							54
57	CT Scan	8,926,040							57
58	MRI	2,022,853							58
60	Laboratory	12,178,807							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	2,794,895							65
66	Physical Therapy	2,990,439							66
69	Electrocardiology	861,106							69
71	Medical Supplies Charged to Pat	1,252,445							71
72	Impl. Dev. Charged to Patients	390,636							72
73	Drugs Charged to Patients	2,712,032							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	1,597,824							88
90	Clinic	402,350							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	4,549,226							91
92	Observation Beds (Non-Distinct)	316,993							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	49,872,961							200

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART V

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

(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	0.549605							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.359585							54
57	CT Scan	0.062441							57
58	MRI	0.300438							58
60	Laboratory	0.242012							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.329125							65
66	Physical Therapy	0.363533							66
69	Electrocardiology	0.172791							69
71	Medical Supplies Charged to Pat	0.447050							71
72	Impl. Dev. Charged to Patients	1.096937							72
73	Drugs Charged to Patients	0.563854							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.133588							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.666482							91
92	Observation Beds (Non-Distinct)	1.628203							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [] 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)	2,470	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,882	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,591	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	411	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)	137	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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)	10	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,083	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)	411	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)	137	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	120.63	20
21	Total general inpatient routine service cost (see instructions)	4,314,778	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)	3,619	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,206	25
26	Total swing-bed cost (see instructions)	976,780	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,337,998	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,337,998	37

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF 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)					1,773.64	38
39	Program general inpatient routine service cost (line 9 x line 38)					1,920,852	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					1,920,852	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
						1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					910,518	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					2,831,370	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)						52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise 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)					728,966	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					242,989	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					971,955	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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID 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)					291	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,773.64	88
89	Observation bed cost (line 87 x line 88) (see instructions)					516,129	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	667,007	4,314,778	0.154587	516,129	79,787	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PART I

Check [] Title V - I/P [XX] Hospital [] SUB (Other) [] ICF/IID [] 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)	2,470	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,882	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	1,591	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	411	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)	137	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	30	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)	10	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	145	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	120.63	20
21	Total general inpatient routine service cost (see instructions)	4,314,778	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)	3,619	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,206	25
26	Total swing-bed cost (see instructions)	976,780	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,337,998	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,337,998	37

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PPS
 Applicable Title XVIII, Part A IPF TEFRA
 Boxes: Title XIX - I/P IRF 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)					1,773.64	38	
39	Program general inpatient routine service cost (line 9 x line 38)					257,178	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)					257,178	41	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit						43	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	
						1		
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48	
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					257,178	49	
	PASS THROUGH COST ADJUSTMENTS							
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					39,756	50	
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51	
52	Total Program excludable cost (sum of lines 50 and 51)					39,756	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	

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID 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)					291	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

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/IID [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		1,184,766		30
ANCILLARY SERVICE COST CENTERS					
50	Operating Room	0.549605	169,522	93,170	50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.359585	195,230	70,202	54
57	CT Scan	0.062441	188,160	11,749	57
58	MRI	0.300438	20,899	6,279	58
60	Laboratory	0.242012	562,739	136,190	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.329125	728,632	239,811	65
66	Physical Therapy	0.363533	60,636	22,043	66
69	Electrocardiology	0.172791	14,376	2,484	69
71	Medical Supplies Charged to Patients	0.447050	190,994	85,384	71
72	Impl. Dev. Charged to Patients	1.096937	61,528	67,492	72
73	Drugs Charged to Patients	0.563854	309,620	174,580	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic				88
90	Clinic	1.133588			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.666482	1,702	1,134	91
92	Observation Beds (Non-Distinct Part)	1.628203			92
OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-94, and 96-98)		2,504,038	910,518	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		2,504,038		202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-Z345

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID 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	0.549605			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.359585	5,558	1,999	54
57	CT Scan	0.062441	1,869	117	57
58	MRI	0.300438			58
60	Laboratory	0.242012	68,890	16,672	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.329125	50,030	16,466	65
66	Physical Therapy	0.363533	287,738	104,602	66
69	Electrocardiology	0.172791	480	83	69
71	Medical Supplies Charged to Patients	0.447050	43,325	19,368	71
72	Impl. Dev. Charged to Patients	1.096937			72
73	Drugs Charged to Patients	0.563854	69,925	39,427	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.133588			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.666482			91
92	Observation Beds (Non-Distinct Part)	1.628203			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		527,815	198,734	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		527,815		202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-1345

WORKSHEET D-3

Check Title V Hospital SUB (Other) Swing Bed SNF PPS
 Applicable Title XVIII, Part A IPF SNF Swing Bed NF TEFRA
 Boxes: Title XIX IRF NF ICF/IID 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	0.549605			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.359585			54
57	CT Scan	0.062441			57
58	MRI	0.300438			58
60	Laboratory	0.242012			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.329125			65
66	Physical Therapy	0.363533			66
69	Electrocardiology	0.172791			69
71	Medical Supplies Charged to Patients	0.447050			71
72	Impl. Dev. Charged to Patients	1.096937			72
73	Drugs Charged to Patients	0.563854			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.133588			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.666482			91
92	Observation Beds (Non-Distinct Part)	1.628203			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1345

WORKSHEET E
PART B

Check 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)	5,863,183			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	5,863,183			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over 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)	5,921,815			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	59,489			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,683,076			26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	3,179,250			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)	3,179,250			30
31	Primary payer payments	360			31
32	Subtotal (line 30 minus line 31)	3,178,890			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)	403,083			34
35	Adjusted reimbursable bad debts (see instructions)	262,004			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	392,425			36
37	Subtotal (see instructions)	3,440,894			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,440,894			40
40.01	Sequestration adjustment (see instructions)	68,818			40.01
41	Interim payments	3,336,246			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	35,830			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-1345

WORKSHEET E-1
PART I

Check Hospital SUB (Other)
 Applicable IPF SNF
 Boxes: IRF Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	Total interim payments paid to provider		2,824,485		3,453,612	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 to	.03				3.03	
	Provider	.04				3.04	
		.05				3.05	
		.06				3.06	
		.07				3.07	
		.08				3.08	
		.09				3.09	
		.10				3.10	
		.50				3.50	
		.51	03/31/2016	29,033	03/31/2016	117,366	3.51
	Provider to	.52				3.52	
	Program	.53				3.53	
		.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		-29,033		-117,366	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			2,795,452		3,336,246	4
TO BE COMPLETED BY CONTRACTOR							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)						
		.01				5.01	
		.02				5.02	
	Program to	.03				5.03	
	Provider	.04				5.04	
		.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 to	.52				5.52	
	Program	.53				5.53	
		.54				5.54	
		.55				5.55	
		.56				5.56	
		.57				5.57	
		.58				5.58	
		.59				5.59	
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01				35,830	6.01
		.02		-227,801			6.02
7	Total Medicare program liability (see instructions)			2,567,651		3,372,076	7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)		8

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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 Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		1,093,959		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 to	.03			3.03
	Provider	.04			3.04
		.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider to	.52			3.52
	Program	.53			3.53
		.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			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)		1,093,959		4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program to	.03			5.03
	Provider	.04			5.04
		.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 to	.52			5.52
	Program	.53			5.53
		.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	29,522		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		1,123,481		7
8	Name of Contractor		Contractor Number	NPR Date (Month/Day/Year)	8

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	534	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,083	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	83	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,591	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	53,021,559	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	212,458	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)		8
9	Sequestration adjustment amount (see instructions)		9
10	Calculation of the HIT incentive payment after sequestration (see instructions)		10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

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

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z345

WORKSHEET E-2

Check Title V Swing Bed - SNF
 Applicable 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)	981,675		1
2 Inpatient routine services - swing bed-NF (see instructions)			2
3 Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	200,721		3
4 Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5 Program days	548		5
6 Interns and residents not in approved teaching program (see instructions)			6
7 Utilization review - physician compensation - SNF optional method only			7
8 Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,182,396		8
9 Primary payer payments (see instructions)			9
10 Subtotal (line 8 minus line 9)	1,182,396		10
11 Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12 Subtotal (line 10 minus line 11)	1,182,396		12
13 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	35,987		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)	1,146,409		15
16 Other Adjustments (specify) (see instructions)			16
16.50 Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17 Allowable bad debts (see instructions)			17
17.01 Adjusted reimbursable bad debts (see instructions)			17.01
18 Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19 Total (see instructions)	1,146,409		19
19.01 Sequestration adjustment (see instructions)	22,928		19.01
20 Interim payments	1,093,959		20
21 Tentative settlement (for contractor use only)			21
22 Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	29,522		22
23 Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

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	2,831,370	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	2,831,370	4
5	Primary payer payments		5
6	Total cost (see instructions)	2,850,057	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	2,850,057	19
20	Deductibles (exclude professional component)	254,401	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	2,595,656	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	2,595,656	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,532	25
26	Adjusted reimbursable bad debts (see instructions)	24,396	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	35,088	27
28	Subtotal (sum of lines 24 and 26)	2,620,052	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	2,620,052	30
30.01	Sequestration adjustment (see instructions)	52,401	30.01
31	Interim payments	2,795,452	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	-227,801	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-1345

WORKSHEET E-3
PART VII

Check Title V Hospital NF PPS
 Applicable Title XIX SUB (Other) ICF/IID TEFRA
 Boxes: SNF 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	Inpatient hospital/SNF/NF services	257,178	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	257,178	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	257,178	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	Routine service charges		8
9	Ancillary service charges		9
10	Organ acquisition charges, net of revenue		10
11	Incentive from target amount computation		11
12	Total reasonable charges (sum of lines 8-11)		12
CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a charge basis		13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(c)		14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	15
16	Total customary charges (see instructions)		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		18
19	Interns and residents (see instructions)		19
20	Cost of physicians' services in a teaching hospital (see instructions)		20
21	Cost of covered services (lesser of line 4 or line 16)	257,178	21
PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments		22
23	Outlier payments		23
24	Program capital payments		24
25	Capital exception payments (see instructions)		25
26	Routine and ancillary service other pass through costs		26
27	Subtotal (sum of lines 22 through 26)		27
28	Customary charges (Titles V or XIX PPS covered services only)		28
29	Titles V or XIX (sum of lines 21 and 27)	257,178	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	257,178	31
32	Deductibles		32
33	Coinsurance		33
34	Allowable bad debts (see instructions)		34
35	Utilization review		35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	257,178	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)	257,178	38
39	Direct graduate medical education payments (from Wkst. E-4)		39
40	Total amount payable to the provider (sum of lines 38 and 39)	257,178	40
41	Interim payments		41
42	Balance due provider/program (line 40 minus line 41)	257,178	42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	5,316,088				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	5,795,084				4
5	Other receivables	729,228				5
6	Allowances for uncollectible notes and accounts receivable	-1,621,129				6
7	Inventory	414,387				7
8	Prepaid expenses	563,647				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	11,197,305				11
FIXED ASSETS						
12	Land	134,756				12
13	Land improvements	1,171,121				13
14	Accumulated depreciation	-789,990				14
15	Buildings	35,103,374				15
16	Accumulated depreciation	-8,891,690				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	2,745,942				19
20	Accumulated depreciation	-1,256,097				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	10,446,898				23
24	Accumulated depreciation	-7,804,889				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	30,859,425				30
OTHER ASSETS						
31	Investments	2,935,271				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	1,721,380				34
35	Total other assets (sum of lines 31-34)	4,656,651				35
36	Total assets (sum of lines 11, 30 and 35)	46,713,381				36
Liabilities and Fund Balances (Omit Cents)						
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	975,422				37
38	Salaries, wages and fees payable	790,131				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	645,384				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds	1,056,266				43
44	Other current liabilities	459,431				44
45	Total current liabilities (sum of lines 37 thru 44)	3,926,634				45
LONG TERM LIABILITIES						
46	Mortgage payable	16,077,500				46
47	Notes payable	2,548,542				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	18,626,042				50
51	Total liabilities (sum of lines 45 and 50)	22,552,676				51
CAPITAL ACCOUNTS						
52	General fund balance	24,160,705				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	24,160,705				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	46,713,381				60

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	Fund balances at beginning of period		24,757,603			1
2	Net income (loss) (from Worksheet G-3, line 29)		-596,898			2
3	Total (sum of line 1 and line 2)		24,160,705			3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		24,160,705			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		24,160,705			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	Fund balances at beginning of period					1
2	Net income (loss) (from Worksheet G-3, line 29)					2
3	Total (sum of line 1 and line 2)					3
4	Additions (credit adjustments) (specify)					4
5						5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)					11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)					19

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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	2,730,452		2,730,452	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	418,146		418,146	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)	3,148,598		3,148,598	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)	3,148,598		3,148,598	17
18	Ancillary services	4,508,613	39,326,959	43,835,572	18
19	Outpatient services		7,389,911	7,389,911	19
20	Rural Health Clinic (RHC)		1,597,824	1,597,824	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	OTHER PATIENT REVENUES		1,564,527	1,564,527	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	7,657,211	49,879,221	57,536,432	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		28,981,889	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)		28,981,889	43

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	57,536,432	1
2	Less contractual allowances and discounts on patients' accounts	30,532,286	2
3	Net patient revenues (line 1 minus line 2)	27,004,146	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	28,981,889	4
5	Net income from service to patients (line 3 minus line 4)	-1,977,743	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	8,548	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts	1,894	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	142,097	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts		18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen	62,738	20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (PROPERTY TAX REVENUE)	254,628	24
24.01	Other (OTHER OPERATING INCOME (EXPENSE))	78,291	24.01
24.02	Other (NONCAPITAL GRANTS AND CONTRIBUTIONS)	428,912	24.02
24.03	Other (340(B) REVENUE)	435,974	24.03
25	Total other income (sum of lines 6-24)	1,413,082	25
26	Total (line 5 plus line 25)	-564,661	26
27	Other expenses (LOSS ON DISPOSITION OF EQUIPMENT)	32,237	27
28	Total other expenses (sum of line 27 and subscripts)	32,237	28
29	Net income (or loss) for the period (line 26 minus line 28)	-596,898	29

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5.01	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	BUSINESS SERVICES						5.02
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
14.01	PURCHASING						14.01
14.02	CENTRAL SERVICES & SUPPLY						14.02
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
53	Anesthesiology						53
54	Radiology-Diagnostic						54
57	CT Scan						57
58	MRI						58
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic						88
90	Clinic						90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
192.01	TEMPORARILY IDLE SPACE						192.01
192.02	STH FAM HLTH CRT						192.02
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

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

COMPONENT CCN: 14-3413

WORKSHEET M-1

Check applicable box: RHC I FQHC

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	429,615	27,742	457,357	-159,203	298,154		298,154	1
2	Physician Assistant								2
3	Nurse Practitioner	368,771	23,813	392,584		392,584		392,584	3
4	Visiting Nurse								4
5	Other Nurse	191,975	12,397	204,372		204,372		204,372	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 through 9)	990,361	63,952	1,054,313	-159,203	895,110		895,110	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		16,740	16,740		16,740		16,740	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 through 20)		16,740	16,740		16,740		16,740	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	990,361	80,692	1,071,053	-159,203	911,850		911,850	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	125,544	204,322	329,866	-24,938	304,928		304,928	30
31	Total Facility Overhead (sum of lines 29 and 30)	125,544	204,322	329,866	-24,938	304,928		304,928	31
32	Total facility costs (sum of lines 22, 28 and 31)	1,115,905	285,014	1,400,919	-184,141	1,216,778		1,216,778	32

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3413

WORKSHEET M-2

Check applicable box: RHC I FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	0.77	2,470	4,200	3,234		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	3.19	10,172	2,100	6,699		3
4	Subtotal (sum of lines 1 through 3)	3.96	12,642		9,933	12,642	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	3.96	12,642			12,642	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		911,850	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)			11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		911,850	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)		304,928	14
15	Parent provider overhead allocated to facility (see instructions)		797,425	15
16	Total overhead (sum of lines 14 and 15)		1,102,353	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		1,102,353	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		1,102,353	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)		2,014,203	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.

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3413

WORKSHEET M-3

Check applicable boxes: RHC I Title V Title XIX
 FQHC Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	2,014,203	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,014,203	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	12,642	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	12,642	6
7	Adjusted cost per visit (line 3 divided by line 6)	159.33	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	116.67	116.67		8
9	Rate for program covered visits (see instructions)	159.33	159.33	159.33	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		2,039		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		324,874		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		324,874		16
16.01	Total program charges (see instructions)(from contractor's records)		281,213		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)		230,588		16.04
16.05	Total program cost (see instructions)		230,588		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		36,639		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		48,915		19
20	Net Medicare cost excluding vaccines (see instructions)		230,588		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				21
22	Total reimbursable Program cost (line 20 plus line 21)		230,588		22
23	Allowable bad debts (see instructions)				23
23.01	Adjusted reimbursable bad debts (see instructions)				23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)				24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		230,588		26
26.01	Sequestration adjustment (see instructions)		4,612		26.01
27	Interim payments		174,140		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		51,836		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3413

WORKSHEET M-4

Check applicable boxes: RHC I Title V Title XIX
 FQHC Title XVIII

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	895,110	895,110	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	911,850	911,850	6
7	Total overhead (from Wkst. M-2, line 16)	1,102,353	1,102,353	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries			13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			16

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/25/2016 Run Time: 07:20 Version: 2016.05 (08/16/2016)
--	---------------------------------------	--	--

**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 I FQHC

		Part B		
DESCRIPTION		mm/dd/yyyy	Amount	
		1	2	
1	Total interim payments paid to provider		184,495	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero			2
3	List separately each retroactive lump sum adjustment 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 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	03/31/2016	3.51
	Provider	.52	10,355	3.52
	to	.53		3.53
	Program	.54		3.54
		.55		3.55
		.56		3.56
		.57		3.57
		.58		3.58
		.59		3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	-10,355	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		174,140	
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 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	Determine net settlement amount (balance due) based on the cost report (1)	.01	51,836	6.01
		.02		6.02
7	Total Medicare program liability (see instructions)		225,976	
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.