

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**WORKSHEET S
PARTS I, II & III****PART I - COST REPORT STATUS**

Provider use only		1. ☐ Electronically filed cost report 2. ☒ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.		Date: 08/30/2019 Time: 11:41	
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL 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 04/01/2018 and ending 03/31/2019, 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.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

CHIEF FINANCIAL OFFICER
 Title

 Date

PART III - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		124,012	-686,691		174,711	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-175,684				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			88,318			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-51,672	-598,373		174,711	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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

								Payment System (P, T, O, or N)		
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	V	XVIII	XIX	
	0	1	2	3	4	5	6	7	8	
3	Hospital	SALEM TOWNSHIP HOSPITAL	14-1345	16460	1	07 / 01 / 1966	N	O	O	3
4	Subprovider - IPF									4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF	SALEM S/B SNF	14-Z345	16460		12 / 17 / 1986	N	O	N	7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC	STH 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 / 2018	To: 03 / 31 / 2019		20
21	Type of control (see instructions)	12			21

Inpatient PPS Information

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (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)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
		V	XVIII	XIX
	Prospective Payment System (PPS)-Capital	1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	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

		1	2	3	
56	Teaching Hospitals 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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
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. Enter in column 4, the 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. Enter in column 4 direct the 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 through 67. (see instructions)	N			63
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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 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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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
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

		1	2	
105	Does this hospital qualify as a 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
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	109

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	N		111

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-L, 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
118.01	List amounts of malpractice premiums and paid losses:	Premiums	Paid Losses	Self Insurance
		220,338		
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 care related taxes as defined in §1903(w)(3) of the Act? 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 in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

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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 the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

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

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1		168
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)			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)	10 / 01 / 2017	12 / 31 / 2017	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

COMPLETED BY ALL HOSPITALS

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

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

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	N		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see 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		Y	
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		N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B		
		Y/N	Date	Y/N	Date	
PS&R Report Data		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	08/12/2019	Y	08/08/2018	17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: RECLASS OF MED SUPPLIES, CT, AND MR	Y		Y		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**WORKSHEET S-2
PART II**

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

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

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

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

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

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

		Y/N	Date	
Home Office Costs		1	2	
36	Are home office costs claimed on the cost report?	N		36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40

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

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
**WORKSHEET S-3
PART I**

		Inpatient Days / Outpatient Visits / Trips								
	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	41,712.00		1,210	118	1,738	1
2	HMO and other (see instructions)						128			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						886		924	5
6	Hospital Adults & Peds. Swing Bed NF								7	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	41,712.00		2,096	118	2,669	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	41,712.00		2,096	118	2,669	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					1,900		11,691	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days								237	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
33.01	LTCH site neutral days and discharges									33.01

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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)					322	33	454	1
2	HMO and other (see instructions)					35			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)		157.76			322	33	454	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		14.23						26
27	Total (sum of lines 14-26)		171.99						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

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

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

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

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3413

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

1	Street: 1201 RICKER DRIVE	1
2	City: SALEM State: IL ZIP Code: 62881 County: MARION	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

	Grant Award	Date	
	1	2	
4	Community Health Center (Section 330(d), PHS Act)		4
5	Migrant Health Center (Section 329(d), PHS Act)		5
6	Health Services for the Homeless (Section 340(d), PHS		6
7	Appalachian Regional Commission		7
8	Look-alikes		8
9	OTHER		9

	1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N	10

Facility hours of operations (1)

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

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

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

	Y/N	V	XVIII	XIX	Total Visits	
	1	2	3	4	5	
15	Have you provided all or substantially all GME cost? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in columns 2, 3, and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)					15

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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)	0.412820	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	1,473,316	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 and/or supplemental payments from Medicaid?	N	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid	979,876	5
6	Medicaid charges	1,609,788	6
7	Medicaid cost (line 1 times line 6)	664,553	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

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

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

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

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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (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)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	53,786	113,687	167,473	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	22,204	113,687	135,891	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	22,204	113,687	135,891	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	1,844,394	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	401,241	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	617,294	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	1,227,100	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	722,624	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	858,515	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	858,515	31

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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		1,022,479	1,022,479	311,977	1,334,456		1,334,456	1
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2		560,585	560,585	267,840	828,425		828,425	1.01
2	00200	Cap Rel Costs-Mvble Equip		621,432	621,432	690,493	1,311,925	-3,994	1,307,931	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department	157,292	2,391,601	2,548,893		2,548,893	-78,029	2,470,864	4
5.01	00592	ADMINISTRATIVE & ACCOUNTING	985,690	2,301,435	3,287,125	-601,918	2,685,207	-130,514	2,554,693	5.01
5.02	00591	BUSINESS SERVICES	524,465	211,792	736,257	-1,421	734,836	-13,558	721,278	5.02
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	271,864	667,642	939,506	-1,083	938,423		938,423	7
8	00800	Laundry & Linen Service	43,341	19,028	62,369		62,369		62,369	8
9	00900	Housekeeping	206,998	84,568	291,566		291,566		291,566	9
10	01000	Dietary	269,179	390,255	659,434	-552,630	106,804	-22,414	84,390	10
11	01100	Cafeteria				551,601	551,601	-125,562	426,039	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	47,358	4,767	52,125		52,125		52,125	13
14	01400	Central Services & Supply								14
14.01	01401	PURCHASING	101,803	27,883	129,686	-3,180	126,506		126,506	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	18,695	406,373	425,068	-403,620	21,448		21,448	14.02
15	01500	Pharmacy	51,117	1,549,451	1,600,568	-59,724	1,540,844		1,540,844	15
16	01600	Medical Records & Library	226,472	86,958	313,430		313,430		313,430	16
17	01700	Social Service								17
19	01900	Nonphysician Anesthetists				530,000	530,000	-530,000		19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,829,854	616,197	2,446,051	179,471	2,625,522	-742,520	1,883,002	30
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	586,756	539,924	1,126,680	-121,692	1,004,988	-91,250	913,738	50
53	05300	Anesthesiology		559,241	559,241	-559,241				53
54	05400	Radiology-Diagnostic	557,459	472,664	1,030,123	-57,600	972,523		972,523	54
57	05700	CT Scan	78,362	98,439	176,801		176,801		176,801	57
58	05800	MRI	69,668	308,120	377,788	-298,800	78,988		78,988	58
60	06000	Laboratory	582,877	1,086,073	1,668,950	-24,502	1,644,448		1,644,448	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	357,056	136,629	493,685	-8,795	484,890	-55,218	429,672	65
66	06600	Physical Therapy		579,393	579,393		579,393		579,393	66
69	06900	Electrocardiology	39,911	82,967	122,878		122,878	-29,809	93,069	69
71	07100	Medical Supplies Charged to Patients				403,620	403,620		403,620	71
72	07200	Impl. Dev. Charged to Patients		397,448	397,448		397,448		397,448	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	1,386,169	322,729	1,708,898	-195,538	1,513,360		1,513,360	88
90	09000	Clinic	133,178	18,621	151,799	-2,016	149,783		149,783	90
90.01	09001	SALEM MEDICAL CLINIC								90.01
91	09100	Emergency	1,046,358	2,156,646	3,203,004	-6,048	3,196,956	-954,546	2,242,410	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		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)	9,571,922	17,721,340	27,293,262	37,194	27,330,456	-2,806,422	24,524,034	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen	50,570	51,623	102,193		102,193		102,193	190
192	19200	Physicians' Private Offices	58,954	3,639	62,593		62,593		62,593	192
192.01	19201	TEMPORARILY IDLE SPACE								192.01
192.02	19202	STH FAM HLTH CRT	710,543	106,981	817,524	-2,248	815,276		815,276	192.02
192.03	19203	RISE OUTREACH LAB	1,419	74,818	76,237	-34,946	41,291		41,291	192.03
194	07950	LITIGATION COSTS		45,088	45,088		45,088		45,088	194
200		TOTAL (sum of lines 118-199)	10,393,408	18,003,489	28,396,897		28,396,897	-2,806,422	25,590,475	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES				
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER
		1	2	3	4	5
1	TO RECLASS CAFETERIA COST	A	Cafeteria	11	225,162	326,439
500	Total reclassifications				225,162	326,439
	Code Letter - A					
1	TO RECLASSIFY SUPPLY COST	B	Medical Supplies Charged to P	71	18,695	384,925
500	Total reclassifications				18,695	384,925
	Code Letter - B					
1	TO RECLASS RENTALS	C	Cap Rel Costs-Mvble Equip	2		682,908
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
500	Total reclassifications					682,908
	Code Letter - C					
1	TO RECLASS CRNA COST	D	Nonphysician Anesthetists	19		530,000
500	Total reclassifications					530,000
	Code Letter - D					
1	TO RECLASS REMAINING ANESTHESIA SUPP	E	Operating Room	50		29,241
500	Total reclassifications					29,241
	Code Letter - E					
1	TO RECLASS INTEREST EXPENSE	F	Cap Rel Costs-Bldg & Fixt	1		202,118
2			NEW CAP-REL CSTS-BLDGS & FIX	1.01		267,840
3			Cap Rel Costs-Mvble Equip	2		7,585
500	Total reclassifications					477,543
	Code Letter - F					
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G				
500	Total reclassifications					
	Code Letter - G					
1	TO RECLASS OTHER CAPITAL COSTS	H	Cap Rel Costs-Bldg & Fixt	1		109,859
500	Total reclassifications					109,859
	Code Letter - H					
1	TO RECLASS OUTREACH LAB	I	ADMINISTRATIVE & ACCOUNTING	5.01		34,946
500	Total reclassifications					34,946
	Code Letter - I					
1	RECLASS HOSPITALIST SERVICES	K	Adults & Pediatrics	30	176,570	18,890
500	Total reclassifications				176,570	18,890
	Code Letter - K					
	GRAND TOTAL (Increases)				420,427	2,594,751

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

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	TO RECLASS CAFETERIA COST	A	Dietary	10	225,162	326,439		1
500	Total reclassifications				225,162	326,439		500
	Code letter - A							
1	TO RECLASSIFY SUPPLY COST	B	CENTRAL SERVICES & SUPPLY	14.02	18,695	384,925		1
500	Total reclassifications				18,695	384,925		500
	Code letter - B							
1	TO RECLASS RENTALS	C	ADMINISTRATIVE & ACCOUNTING	5.01		49,462	10	1
2			BUSINESS SERVICES	5.02		1,421		2
3			Operation of Plant	7		1,083		3
4			Dietary	10		1,029		4
5			PURCHASING	14.01		3,180		5
6			Pharmacy	15		59,724		6
7			Adults & Pediatrics	30		15,989		7
8			Operating Room	50		150,933		8
9			Radiology-Diagnostic	54		57,600		9
10			MRI	58		298,800		10
11			Laboratory	60		24,502		11
12			Respiratory Therapy	65		8,795		12
13			Rural Health Clinic	88		78		13
14			Clinic	90		2,016		14
15			Emergency	91		6,048		15
16			STH FAM HLTH CRT	192.02		2,248		16
500	Total reclassifications					682,908		500
	Code letter - C							
1	TO RECLASS CRNA COST	D	Anesthesiology	53		530,000		1
500	Total reclassifications					530,000		500
	Code letter - D							
1	TO RECLASS REMAINING ANESTHESIA SUPP	E	Anesthesiology	53		29,241		1
500	Total reclassifications					29,241		500
	Code letter - E							
1	TO RECLASS INTEREST EXPENSE	F	ADMINISTRATIVE & ACCOUNTING	5.01		477,543	14	1
2							14	2
3							14	3
500	Total reclassifications					477,543		500
	Code letter - F							
1	TO RECLASS PHYSICIAN PORTION FOR RHC	G						1
500	Total reclassifications							500
	Code letter - G							
1	TO RECLASS OTHER CAPITAL COSTS	H	ADMINISTRATIVE & ACCOUNTING	5.01		109,859	14	1
500	Total reclassifications					109,859		500
	Code letter - H							
1	TO RECLASS OUTREACH LAB	I	RISE OUTREACH LAB	192.03		34,946		1
500	Total reclassifications					34,946		500
	Code letter - I							
1	RECLASS HOSPITALIST SERVICES	K	Rural Health Clinic	88	176,570	18,890		1
500	Total reclassifications				176,570	18,890		500
	Code letter - K							
	GRAND TOTAL (Decreases)				420,427	2,594,751		

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

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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	203,353					203,353		1
2	Land Improvements	1,180,059					1,180,059		2
3	Buildings and Fixtures	35,145,205				7,050	35,138,155		3
4	Building Improvements								4
5	Fixed Equipment	2,785,564	5,375		5,375		2,790,939		5
6	Movable Equipment	9,921,213	654,662		654,662	485,672	10,090,203		6
7	HIT-designated Assets	1,079,269					1,079,269		7
8	Subtotal (sum of lines 1-7)	50,314,663	660,037		660,037	492,722	50,481,978		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	50,314,663	660,037		660,037	492,722	50,481,978		10

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

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,022,479						1,022,479	1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	560,585						560,585	1.01
2	Cap Rel Costs-Mvble Equip	621,432						621,432	2
3	Total (sum of lines 1-2)	2,204,496						2,204,496	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi				0.000000					1
1.01	NEW CAP-REL CSTS-BLDGS				0.000000					1.01
2	Cap Rel Costs-Mvble Equip				0.000000					2
3	Total (sum of lines 1-2)				0.000000					3

	Description	SUMMARY OF CAPITAL							
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	1,022,479					311,977	1,334,456	1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	560,585					267,840	828,425	1.01
2	Cap Rel Costs-Mvble Equip	621,432	682,908				3,591	1,307,931	2
3	Total (sum of lines 1-2)	2,204,496	682,908				583,408	3,470,812	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.)

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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	-76,190	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	-2,551	BUSINESS SERVICES	5.02		7
8	Television and radio service (chapter 21)	A	-5,461	ADMINISTRATIVE & ACCOUNTING	5.01		8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-1,873,343				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	-125,562	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 and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist		-530,000	Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3	-29,008	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	-1,238	Cap Rel Costs-Mvble Equip	2	14	32
33	TELEPHONE	A	-2,064	BUSINESS SERVICES	5.02		33
34	DIETARY REVENUE	B	-22,414	Dietary	10		34
35	BUS OFFICE COSTS ASSOC W/ PHYS CHG	A	-8,943	BUSINESS SERVICES	5.02		35
36							36
37	PHYSICIAN RECRUITMENT	A	929	ADMINISTRATIVE & ACCOUNTING	5.01		37
38							38
39	LOBBYING PORTION OF DUES	A	-14,846	ADMINISTRATIVE & ACCOUNTING	5.01		39
40	MARKETING	A	-78,029	Employee Benefits Department	4		40
41	MARKETING	A	-34,946	ADMINISTRATIVE & ACCOUNTING	5.01		41
42	PHYSICIAN LAWSUIT WRITE-OFFS	A					42
43	GOODWILL AMORTIZATION- PHY. CLINIC	A					43
44	IMPAIRED ASSETS	A	-2,756	Cap Rel Costs-Mvble Equip	2	14	44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-2,806,422				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

WORKSHEET A-8-1

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

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

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

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

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

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

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

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	50	Operating Room OR	91,250	91,250						1
2	60	Laboratory LABORATORY	68,310		68,310					2
3	65	Respiratory Therapy RESPIRATORY THE	55,218	55,218						3
4	69	Electrocardiology ELECTROCARDIOLO	29,809	29,809						4
5	91	Emergency EMERGENCY	2,006,614	954,546	1,052,068					5
6	30	Adults & Pediatrics HOSPITALIST	742,520	742,520						6
7	53	Anesthesiology ANESTHESIOLOGY	24,000		24,000					7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	3,017,721	1,873,343	1,144,378					200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	50	Operating Room OR							91,250	1
2	60	Laboratory LABORATORY								2
3	65	Respiratory Therapy RESPIRATORY THE							55,218	3
4	69	Electrocardiology ELECTROCARDIOLO							29,809	4
5	91	Emergency EMERGENCY							954,546	5
6	30	Adults & Pediatrics HOSPITALIST							742,520	6
7	53	Anesthesiology ANESTHESIOLOGY								7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							1,873,343	200

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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)						12	1
2	Line 1 multiplied by 15 hours per week						180	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)							3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)							4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)							5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)							6
7	Standard travel expense rate						5.80	7
8	Optional travel expense rate							8
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1	2	3	4	5		
9	Total hours worked		470.00					9
10	AHSEA (see instructions)		79.51					10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	39.76	39.76					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)	37,370		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)	37,370		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)	37,370		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)	37,370		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

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

Check applicable box: ☒ **Occupational** ☐ **Physical** ☐ **Respiratory** ☐ **Speech Pathology**

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	37,370	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)	37,370	63
64	Total cost of outside supplier services (from provider records)	66,378	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)	29,008	65

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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)						12	1
2	Line 1 multiplied by 15 hours per week						180	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)							3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)							4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)							5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)							6
7	Standard travel expense rate						5.80	7
8	Optional travel expense rate							8
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1	2	3	4	5		
9	Total hours worked	1,632.00	3,109.00		5,030.00			9
10	AHSEA (see instructions)	53.61	83.90		62.93			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)	41.95	41.95					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)		87,492	14
15	Therapists (column 2, line 9 times column 2, line 10)		260,845	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)		348,337	17
18	Aides (column 4, line 9 times column 4, line 10)		316,538	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)		664,875	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)		664,875	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

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

Check applicable box: ☐ Occupational ☒ Physical ☐ Respiratory ☐ Speech Pathology

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	664,875	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)	664,875	63
64	Total cost of outside supplier services (from provider records)	475,350	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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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)					4	1
2	Line 1 multiplied by 15 hours per week					60	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visits(s)) (see instructions)						6
7	Standard travel expense rate					5.80	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		8.00				9
10	AHSEA (see instructions)		76.40				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	38.20	38.20				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)		14
15	Therapists (column 2, line 9 times column 2, line 10)	611	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)	611	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)	611	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)	76.38	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	4,583	22
23	Total salary equivalency (see instructions)	4,583	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

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS**WORKSHEET A-8-3
PARTS V-VI**

Check applicable box: ☐ Occupational ☐ Physical ☐ Respiratory ☒ Speech Pathology

PART V - OVERTIME COMPUTATION

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	4,583	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	4,583	63
64	Total cost of outside supplier services (from provider records)	398	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

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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	1,334,456	1,334,456					1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	828,425		828,425				1.01
2	Cap Rel Costs-Mvble Equip	1,307,931			1,307,931			2
4	Employee Benefits Department	2,470,864	10,058		2,025	2,482,947		4
5.01	ADMINISTRATIVE & ACCOUNTING	2,554,693	365,841	47,262	17,266	239,096	3,224,158	5.01
5.02	BUSINESS SERVICES	721,278	74,730	972	187,152	127,218	1,111,350	5.02
6	Maintenance & Repairs							6
7	Operation of Plant	938,423	240,643	40,114	27,340	65,945	1,312,465	7
8	Laundry & Linen Service	62,369	10,540			10,513	83,422	8
9	Housekeeping	291,566	8,757			50,211	350,534	9
10	Dietary	84,390	27,749		9,794	10,677	132,610	10
11	Cafeteria	426,039	15,152			54,617	495,808	11
12	Maintenance of Personnel							12
13	Nursing Administration	52,125	4,338		601	11,487	68,551	13
14	Central Services & Supply							14
14.01	PURCHASING	126,506	15,746		3,189	24,694	170,135	14.01
14.02	CENTRAL SERVICES & SUPPLY	21,448					21,448	14.02
15	Pharmacy	1,540,844		27,788	60,297	12,399	1,641,328	15
16	Medical Records & Library	313,430	14,927		2,088	54,935	385,380	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	1,883,002		392,444	70,940	486,695	2,833,081	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	913,738	99,040		206,862	142,328	1,361,968	50
53	Anesthesiology							53
54	Radiology-Diagnostic	972,523	87,504		191,019	135,221	1,386,267	54
57	CT Scan	176,801	7,439		99,220	19,008	302,468	57
58	MRI	78,988	5,415		299,623	16,899	400,925	58
60	Laboratory	1,644,448	57,923		54,334	141,387	1,898,092	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	429,672	29,420	27,035	23,367	86,610	596,104	65
66	Physical Therapy	579,393	81,993		2,686		664,072	66
69	Electrocardiology	93,069		10,794	6,613	9,681	120,157	69
71	Medical Supplies Charged to Patients	403,620		16,167		4,535	424,322	71
72	Impl. Dev. Charged to Patients	397,448					397,448	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	1,513,360		97,709	4,389	293,409	1,908,867	88
90	Clinic	149,783	37,148	8,898	4,069	32,305	232,203	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	2,242,410	68,223		17,102	253,812	2,581,547	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	24,524,034	1,262,586	669,183	1,289,976	2,283,682	24,075,702	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	102,193	13,641		2,963	12,267	131,064	190
192	Physicians' Private Offices	62,593		159,242	10,154	14,300	246,289	192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	815,276	58,229		4,838	172,354	1,050,697	192.02
192.03	RISE OUTREACH LAB	41,291				344	41,635	192.03
194	LITIGATION COSTS	45,088					45,088	194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	25,590,475	1,334,456	828,425	1,307,931	2,482,947	25,590,475	202

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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	3,224,158						5.01
5.02	BUSINESS SERVICES	159,997	1,271,347					5.02
6	Maintenance & Repairs							6
7	Operation of Plant	188,950		1,501,415				7
8	Laundry & Linen Service	12,010		13,976	109,408			8
9	Housekeeping	50,465		11,611	18,275	430,885		9
10	Dietary	19,091		36,794	2,276	13,537	204,308	10
11	Cafeteria	71,379		20,091				11
12	Maintenance of Personnel							12
13	Nursing Administration	9,869		5,752				13
14	Central Services & Supply							14
14.01	PURCHASING	24,494		20,879				14.01
14.02	CENTRAL SERVICES & SUPPLY	3,088				6,273		14.02
15	Pharmacy	236,295		24,352		6,934		15
16	Medical Records & Library	55,482		19,793		4,623		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	407,859	100,930	343,913	44,845	128,109	204,308	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	196,077	85,877	131,327	13,434	34,339		50
53	Anesthesiology							53
54	Radiology-Diagnostic	199,575	116,870	116,029	13,165	27,075		54
57	CT Scan	43,545	223,414	9,864		8,255		57
58	MRI	57,720	38,321	7,180		3,962		58
60	Laboratory	273,261	304,817	76,806		39,291		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	85,819	78,196	62,702		10,236		65
66	Physical Therapy	95,604	62,732	108,722	4,106	5,283		66
69	Electrocardiology	17,299	14,648	9,460		1,981		69
71	Medical Supplies Charged to Patients	61,088	27,061	14,168				71
72	Impl. Dev. Charged to Patients	57,219	13,076					72
73	Drugs Charged to Patients		54,768					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	274,812	33,939	85,627		31,367		88
90	Clinic	33,429	10,904	57,056		12,877		90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	371,655	105,794	90,463	13,307	54,810		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	3,006,082	1,271,347	1,266,565	109,408	388,952	204,308	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	18,869		18,088		11,556		190
192	Physicians' Private Offices	35,457		139,551		21,132		192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	151,265		77,211		9,245		192.02
192.03	RISE OUTREACH LAB	5,994						192.03
194	LITIGATION COSTS	6,491						194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	3,224,158	1,271,347	1,501,415	109,408	430,885	204,308	202

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

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14.01	14.02	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	587,278						11
12	Maintenance of Personnel							12
13	Nursing Administration	1,206	85,378					13
14	Central Services & Supply							14
14.01	PURCHASING	9,936		225,444				14.01
14.02	CENTRAL SERVICES & SUPPLY			207	31,016			14.02
15	Pharmacy	7,814		1,353		1,918,076		15
16	Medical Records & Library	30,193		248			495,719	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	150,147	37,049	7,139	1,385		34,352	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	47,605	11,749	31,717	9,087		49,149	50
53	Anesthesiology							53
54	Radiology-Diagnostic	50,692		50,053	394			54
57	CT Scan	6,415		4,415	115			57
58	MRI	6,270		736	17			58
60	Laboratory	63,619		111,284	1,522		223,020	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	36,994		1,886	20		9,513	65
66	Physical Therapy			967	2		36,994	66
69	Electrocardiology			328	3		31,709	69
71	Medical Supplies Charged to Patients	3,039						71
72	Impl. Dev. Charged to Patients				13,894			72
73	Drugs Charged to Patients					1,918,076		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	69,021	16,928	2,716	67		26,953	88
90	Clinic	10,466		852	831			90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	79,632	19,652	8,084	2,226		84,029	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	573,049	85,378	221,985	29,563	1,918,076	495,719	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8,634		827	1,450			190
192	Physicians' Private Offices	5,595		450				192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT			1,210	3			192.02
192.03	RISE OUTREACH LAB			972				192.03
194	LITIGATION COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	587,278	85,378	225,444	31,016	1,918,076	495,719	202

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

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
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	4,293,117		4,293,117			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,972,329		1,972,329			50
53	Anesthesiology						53
54	Radiology-Diagnostic	1,960,120		1,960,120			54
57	CT Scan	598,491		598,491			57
58	MRI	515,131		515,131			58
60	Laboratory	2,991,712		2,991,712			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	881,470		881,470			65
66	Physical Therapy	978,482		978,482			66
69	Electrocardiology	195,585		195,585			69
71	Medical Supplies Charged to Patients	529,678		529,678			71
72	Impl. Dev. Charged to Patients	481,637		481,637			72
73	Drugs Charged to Patients	1,972,844		1,972,844			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	2,450,297		2,450,297			88
90	Clinic	358,618		358,618			90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	3,411,199		3,411,199			91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	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)	23,561,702		23,561,702			118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	190,488		190,488			190
192	Physicians' Private Offices	448,474		448,474			192
192.01	TEMPORARILY IDLE SPACE						192.01
192.02	STH FAM HLTH CRT	1,289,631		1,289,631			192.02
192.03	RISE OUTREACH LAB	48,601		48,601			192.03
194	LITIGATION COSTS	51,579		51,579			194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	25,590,475		25,590,475			202

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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		10,058		2,025	12,083	12,083	4
5.01	ADMINISTRATIVE & ACCOUNTING		365,841	47,262	17,266	430,369	1,163	5.01
5.02	BUSINESS SERVICES		74,730	972	187,152	262,854	619	5.02
6	Maintenance & Repairs							6
7	Operation of Plant		240,643	40,114	27,340	308,097	321	7
8	Laundry & Linen Service		10,540			10,540	51	8
9	Housekeeping		8,757			8,757	244	9
10	Dietary		27,749		9,794	37,543	52	10
11	Cafeteria		15,152			15,152	266	11
12	Maintenance of Personnel							12
13	Nursing Administration		4,338		601	4,939	56	13
14	Central Services & Supply							14
14.01	PURCHASING		15,746		3,189	18,935	120	14.01
14.02	CENTRAL SERVICES & SUPPLY							14.02
15	Pharmacy			27,788	60,297	88,085	60	15
16	Medical Records & Library		14,927		2,088	17,015	267	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			392,444	70,940	463,384	2,373	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		99,040		206,862	305,902	692	50
53	Anesthesiology							53
54	Radiology-Diagnostic		87,504		191,019	278,523	658	54
57	CT Scan		7,439		99,220	106,659	92	57
58	MRI		5,415		299,623	305,038	82	58
60	Laboratory		57,923		54,334	112,257	688	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		29,420	27,035	23,367	79,822	421	65
66	Physical Therapy		81,993		2,686	84,679		66
69	Electrocardiology			10,794	6,613	17,407	47	69
71	Medical Supplies Charged to Patients			16,167		16,167	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			97,709	4,389	102,098	1,427	88
90	Clinic		37,148	8,898	4,069	50,115	157	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency		68,223		17,102	85,325	1,235	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)		1,262,586	669,183	1,289,976	3,221,745	11,113	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		13,641		2,963	16,604	60	190
192	Physicians' Private Offices			159,242	10,154	169,396	70	192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		58,229		4,838	63,067	838	192.02
192.03	RISE OUTREACH LAB						2	192.03
194	LITIGATION COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		1,334,456	828,425	1,307,931	3,470,812	12,083	202

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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	431,532						5.01
5.02	BUSINESS SERVICES	21,415	284,888					5.02
6	Maintenance & Repairs							6
7	Operation of Plant	25,290		333,708				7
8	Laundry & Linen Service	1,607		3,106	15,304			8
9	Housekeeping	6,754		2,581	2,556	20,892		9
10	Dietary	2,555		8,178	318	656	49,302	10
11	Cafeteria	9,554		4,465				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,321		1,279				13
14	Central Services & Supply							14
14.01	PURCHASING	3,278		4,641				14.01
14.02	CENTRAL SERVICES & SUPPLY	413				304		14.02
15	Pharmacy	31,627		5,413		336		15
16	Medical Records & Library	7,426		4,399		224		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	54,590	22,615	76,439	6,274	6,213	49,302	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	26,244	19,242	29,189	1,879	1,665		50
53	Anesthesiology							53
54	Radiology-Diagnostic	26,712	26,186	25,789	1,842	1,313		54
57	CT Scan	5,828	50,059	2,192		400		57
58	MRI	7,725	8,586	1,596		192		58
60	Laboratory	36,574	68,324	17,071		1,905		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	11,486	17,521	13,936		496		65
66	Physical Therapy	12,796	14,056	24,165	574	256		66
69	Electrocardiology	2,315	3,282	2,103		96		69
71	Medical Supplies Charged to Patients	8,176	6,063	3,149				71
72	Impl. Dev. Charged to Patients	7,658	2,930					72
73	Drugs Charged to Patients		12,272					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	36,782	7,604	19,032		1,521		88
90	Clinic	4,474	2,443	12,681		624		90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	49,744	23,705	20,106	1,861	2,658		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	402,344	284,888	281,510	15,304	18,859	49,302	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	2,525		4,020		560		190
192	Physicians' Private Offices	4,746		31,017		1,025		192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	20,246		17,161		448		192.02
192.03	RISE OUTREACH LAB	802						192.03
194	LITIGATION COSTS	869						194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	431,532	284,888	333,708	15,304	20,892	49,302	202

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

	COST CENTER DESCRIPTIONS	CAFETERIA	NURSING ADMINIS- TRATION	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11	13	14.01	14.02	15	16	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES							5.02
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria	29,437						11
12	Maintenance of Personnel							12
13	Nursing Administration	60	7,655					13
14	Central Services & Supply							14
14.01	PURCHASING	498		27,472				14.01
14.02	CENTRAL SERVICES & SUPPLY			25	742			14.02
15	Pharmacy	392		165		126,078		15
16	Medical Records & Library	1,513		30			30,874	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	7,527	3,322	870	33		2,139	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	2,386	1,053	3,865	217		3,061	50
53	Anesthesiology							53
54	Radiology-Diagnostic	2,541		6,099	9			54
57	CT Scan	322		538	3			57
58	MRI	314		90				58
60	Laboratory	3,189		13,561	36		13,891	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,854		230			592	65
66	Physical Therapy			118			2,304	66
69	Electrocardiology			40			1,975	69
71	Medical Supplies Charged to Patients	152						71
72	Impl. Dev. Charged to Patients				334			72
73	Drugs Charged to Patients					126,078		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	3,460	1,518	331	2		1,679	88
90	Clinic	525		104	20			90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	3,991	1,762	985	53		5,233	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	28,724	7,655	27,051	707	126,078	30,874	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	433		101	35			190
192	Physicians' Private Offices	280		55				192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT			147				192.02
192.03	RISE OUTREACH LAB			118				192.03
194	LITIGATION COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	29,437	7,655	27,472	742	126,078	30,874	202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B PART II

	COST CENTER DESCRIPTIONS	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL			
		24	25	26			
	GENERAL SERVICE COST CENTERS						
1	Cap Rel Costs-Bldg & Fixt						1
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	695,081		695,081			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	395,395		395,395			50
53	Anesthesiology						53
54	Radiology-Diagnostic	369,672		369,672			54
57	CT Scan	166,093		166,093			57
58	MRI	323,623		323,623			58
60	Laboratory	267,496		267,496			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	126,358		126,358			65
66	Physical Therapy	138,948		138,948			66
69	Electrocardiology	27,265		27,265			69
71	Medical Supplies Charged to Patients	33,729		33,729			71
72	Impl. Dev. Charged to Patients	10,922		10,922			72
73	Drugs Charged to Patients	138,350		138,350			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	175,454		175,454			88
90	Clinic	71,143		71,143			90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	196,658		196,658			91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	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)	3,136,187		3,136,187			118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	24,338		24,338			190
192	Physicians' Private Offices	206,589		206,589			192
192.01	TEMPORARILY IDLE SPACE						192.01
192.02	STH FAM HLTH CRT	101,907		101,907			192.02
192.03	RISE OUTREACH LAB	922		922			192.03
194	LITIGATION COSTS	869		869			194
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	3,470,812		3,470,812			202

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

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	RECON- CILIATION	ADMINISTRA TIVE & ACC OUNTING ACCUM COST	
		1	1.01	2	4	5A.01	5.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	83,053						1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2		34,075					1.01
2	Cap Rel Costs-Mvble Equip			1,304,341				2
4	Employee Benefits Department	626		2,019	10,236,116			4
5.01	ADMINISTRATIVE & ACCOUNTING	22,769	1,944	17,219	985,690	-3,224,158	22,395,325	5.01
5.02	BUSINESS SERVICES	4,651	40	186,638	524,465		1,111,350	5.02
6	Maintenance & Repairs							6
7	Operation of Plant	14,977	1,650	27,265	271,864		1,312,465	7
8	Laundry & Linen Service	656			43,341		83,422	8
9	Housekeeping	545			206,998		350,534	9
10	Dietary	1,727		9,767	44,017		132,610	10
11	Cafeteria	943			225,162		495,808	11
12	Maintenance of Personnel							12
13	Nursing Administration	270		599	47,358		68,551	13
14	Central Services & Supply							14
14.01	PURCHASING	980		3,180	101,803		170,135	14.01
14.02	CENTRAL SERVICES & SUPPLY						21,448	14.02
15	Pharmacy		1,143	60,132	51,117		1,641,328	15
16	Medical Records & Library	929		2,082	226,472		385,380	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		16,142	70,745	2,006,424		2,833,081	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,164		206,294	586,756		1,361,968	50
53	Anesthesiology							53
54	Radiology-Diagnostic	5,446		190,495	557,459		1,386,267	54
57	CT Scan	463		98,948	78,362		302,468	57
58	MRI	337		298,800	69,668		400,925	58
60	Laboratory	3,605		54,185	582,877		1,898,092	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,831	1,112	23,303	357,056		596,104	65
66	Physical Therapy	5,103		2,679			664,072	66
69	Electrocardiology		444	6,595	39,911		120,157	69
71	Medical Supplies Charged to Patients		665		18,695		424,322	71
72	Impl. Dev. Charged to Patients						397,448	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		4,019	4,377	1,209,599		1,908,867	88
90	Clinic	2,312	366	4,058	133,178		232,203	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	4,246		17,055	1,046,358		2,581,547	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	78,580	27,525	1,286,435	9,414,630	-3,195,150	20,880,552	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	849		2,955	50,570		131,064	190
192	Physicians' Private Offices		6,550	10,126	58,954		246,289	192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT	3,624		4,825	710,543		1,050,697	192.02
192.03	RISE OUTREACH LAB				1,419		41,635	192.03
194	LITIGATION COSTS						45,088	194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,334,456	828,425	1,307,931	2,482,947		3,224,158	202
203	Unit Cost Multiplier (Wkst. B, Part I)	16,067523	24.311812	1.002752	0.242567		0.143966	203
204	Cost to be allocated (Per Wkst. B, Part II)				12,083		431,532	204
205	Unit Cost Multiplier (Wkst. B, Part II)				0.001180		0.019269	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	BUSINESS SERVICES GROSS CHARGES	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA MEALS SERVED	
		5.02	7	8	9	10	11	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2							1.01
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5.01	ADMINISTRATIVE & ACCOUNTING							5.01
5.02	BUSINESS SERVICES	57,723,265						5.02
6	Maintenance & Repairs							6
7	Operation of Plant		70,471					7
8	Laundry & Linen Service		656	15,482				8
9	Housekeeping		545	2,586	1,305			9
10	Dietary		1,727	322	41	5,011		10
11	Cafeteria		943				12,176	11
12	Maintenance of Personnel							12
13	Nursing Administration		270				25	13
14	Central Services & Supply							14
14.01	PURCHASING		980				206	14.01
14.02	CENTRAL SERVICES & SUPPLY				19			14.02
15	Pharmacy		1,143		21		162	15
16	Medical Records & Library		929		14		626	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	4,582,538	16,142	6,346	388	5,011	3,113	30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,899,056	6,164	1,901	104		987	50
53	Anesthesiology							53
54	Radiology-Diagnostic	5,306,253	5,446	1,863	82		1,051	54
57	CT Scan	10,143,658	463		25		133	57
58	MRI	1,739,874	337		12		130	58
60	Laboratory	13,839,922	3,605		119		1,319	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,550,349	2,943		31		767	65
66	Physical Therapy	2,848,200	5,103	581	16			66
69	Electrocardiology	665,081	444		6			69
71	Medical Supplies Charged to Patients	1,228,629	665				63	71
72	Impl. Dev. Charged to Patients	593,693						72
73	Drugs Charged to Patients	2,486,633						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	1,540,923	4,019		95		1,431	88
90	Clinic	495,078	2,678		39		217	90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	4,803,378	4,246	1,883	166		1,651	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	57,723,265	59,448	15,482	1,178	5,011	11,881	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		849		35		179	190
192	Physicians' Private Offices		6,550		64		116	192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		3,624		28			192.02
192.03	RISE OUTREACH LAB							192.03
194	LITIGATION COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,271,347	1,501,415	109,408	430,885	204,308	587,278	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.022025	21.305431	7.066787	330.180077	40.771902	48.232424	203
204	Cost to be allocated (Per Wkst. B, Part II)	284,888	333,708	15,304	20,892	49,302	29,437	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.004935	4.735395	0.988503	16.009195	9.838755	2.417625	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NURSING ADMINIS- TRATION DIRECT NRSNG HRS	PURCHASING COSTED REQUIS.	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT		
		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							11
12	Maintenance of Personnel							12
13	Nursing Administration	149,227						13
14	Central Services & Supply							14
14.01	PURCHASING		1,261,562					14.01
14.02	CENTRAL SERVICES & SUPPLY		1,156	887,150				14.02
15	Pharmacy		7,571		1,000			15
16	Medical Records & Library		1,386			1,876		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	64,756	39,950	39,626		130		30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	20,535	177,488	259,919		186		50
53	Anesthesiology							53
54	Radiology-Diagnostic		280,091	11,259				54
57	CT Scan		24,704	3,291				57
58	MRI		4,120	479				58
60	Laboratory		622,737	43,521		844		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		10,555	561		36		65
66	Physical Therapy		5,414	52		140		66
69	Electrocardiology		1,835	83		120		69
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients			397,448				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	29,587	15,197	1,913		102		88
90	Clinic		4,765	23,774				90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	34,349	45,238	63,659		318		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	149,227	1,242,207	845,585	1,000	1,876		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,630	41,476				190
192	Physicians' Private Offices		2,518					192
192.01	TEMPORARILY IDLE SPACE							192.01
192.02	STH FAM HLTH CRT		6,769	89				192.02
192.03	RISE OUTREACH LAB		5,438					192.03
194	LITIGATION COSTS							194
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	85,378	225,444	31,016	1,918,076	495,719		202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.572135	0.178702	0.034961	1,918.076000	264.242537		203
204	Cost to be allocated (Per Wkst. B, Part II)	7,655	27,472	742	126,078	30,874		204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.051298	0.021776	0.000836	126.078000	16.457356		205

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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		
		13	14.01	14.02	15	16		
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,293,117		4,293,117			30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,972,329		1,972,329			50
53	Anesthesiology						53
54	Radiology-Diagnostic	1,960,120		1,960,120			54
57	CT Scan	598,491		598,491			57
58	MRI	515,131		515,131			58
60	Laboratory	2,991,712		2,991,712			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	881,470		881,470			65
66	Physical Therapy	978,482		978,482			66
69	Electrocardiology	195,585		195,585			69
71	Medical Supplies Charged to Patients	529,678		529,678			71
72	Impl. Dev. Charged to Patients	481,637		481,637			72
73	Drugs Charged to Patients	1,972,844		1,972,844			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	2,450,297		2,450,297			88
90	Clinic	358,618		358,618			90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	3,411,199		3,411,199			91
92	Observation Beds (Non-Distinct Part)	350,905		350,905			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	23,941,615		23,941,615			200
201	Less Observation Beds	350,905		350,905			201
202	Total (line 200 minus line 201)	23,590,710		23,590,710			202

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES
**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	4,132,223		4,132,223				30
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	501,335	2,819,673	3,321,008	0.593895			50
53	Anesthesiology							53
54	Radiology-Diagnostic	297,877	5,008,376	5,306,253	0.369398			54
57	CT Scan	348,136	9,795,522	10,143,658	0.059001			57
58	MRI	42,118	1,697,756	1,739,874	0.296074			58
60	Laboratory	1,101,732	12,738,190	13,839,922	0.216165			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,849,425	1,700,924	3,550,349	0.248277			65
66	Physical Therapy	738,547	2,109,653	2,848,200	0.343544			66
69	Electrocardiology	15,664	649,417	665,081	0.294077			69
71	Medical Supplies Charged to Patients	347,869	880,760	1,228,629	0.431113			71
72	Impl. Dev. Charged to Patients	436,996	156,697	593,693	0.811256			72
73	Drugs Charged to Patients	680,576	1,806,057	2,486,633	0.793380			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		1,540,923	1,540,923				88
90	Clinic	549	494,529	495,078	0.724367			90
90.01	SALEM MEDICAL CLINIC							90.01
91	Emergency	939	4,802,439	4,803,378	0.710167			91
92	Observation Beds (Non-Distinct Part)		450,315	450,315	0.779243			92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	10,493,986	46,651,231	57,145,217				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	10,493,986	46,651,231	57,145,217				202

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)
**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	4,293,117		4,293,117		4,293,117	30
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	1,972,329		1,972,329		1,972,329	50
53	Anesthesiology						53
54	Radiology-Diagnostic	1,960,120		1,960,120		1,960,120	54
57	CT Scan	598,491		598,491		598,491	57
58	MRI	515,131		515,131		515,131	58
60	Laboratory	2,991,712		2,991,712		2,991,712	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	881,470		881,470		881,470	65
66	Physical Therapy	978,482		978,482		978,482	66
69	Electrocardiology	195,585		195,585		195,585	69
71	Medical Supplies Charged to Patients	529,678		529,678		529,678	71
72	Impl. Dev. Charged to Patients	481,637		481,637		481,637	72
73	Drugs Charged to Patients	1,972,844		1,972,844		1,972,844	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	2,450,297		2,450,297		2,450,297	88
90	Clinic	358,618		358,618		358,618	90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	3,411,199		3,411,199		3,411,199	91
92	Observation Beds (Non-Distinct Part)	350,905		350,905			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	23,941,615		23,941,615		23,590,710	200
201	Less Observation Beds	350,905		350,905			201
202	Total (line 200 minus line 201)	23,590,710		23,590,710		23,590,710	202

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)**WORKSHEET C
PART I**

		CHARGES						
	COST CENTER DESCRIPTIONS	Inpatient	Outpatient	Total (column 6 + column 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics							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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)							200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)							202

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY
**WORKSHEET C
PART II**
[] Title V
[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	1,972,329	395,395	1,576,934		50
53	Anesthesiology					53
54	Radiology-Diagnostic	1,960,120	369,672	1,590,448		54
57	CT Scan	598,491	166,093	432,398		57
58	MRI	515,131	323,623	191,508		58
60	Laboratory	2,991,712	267,496	2,724,216		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	881,470	126,358	755,112		65
66	Physical Therapy	978,482	138,948	839,534		66
69	Electrocardiology	195,585	27,265	168,320		69
71	Medical Supplies Charged to Patients	529,678	33,729	495,949		71
72	Impl. Dev. Charged to Patients	481,637	10,922	470,715		72
73	Drugs Charged to Patients	1,972,844	138,350	1,834,494		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	2,450,297	175,454	2,274,843		88
90	Clinic	358,618	71,143	287,475		90
90.01	SALEM MEDICAL CLINIC					90.01
91	Emergency	3,411,199	196,658	3,214,541		91
92	Observation Beds (Non-Distinct Part)	350,905	56,814	294,091		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	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	19,648,498	2,497,920	17,150,578		200
201	Less Observation Beds	350,905	56,814	294,091		201
202	Total	19,297,593	2,441,106	16,856,487		202

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

WORKSHEET C PART II

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio(col. 6 ÷ col. 7)	
		5	6	7	8	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room		1,972,329			50
53	Anesthesiology					53
54	Radiology-Diagnostic		1,960,120			54
57	CT Scan		598,491			57
58	MRI		515,131			58
60	Laboratory		2,991,712			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		881,470			65
66	Physical Therapy		978,482			66
69	Electrocardiology		195,585			69
71	Medical Supplies Charged to Patients		529,678			71
72	Impl. Dev. Charged to Patients		481,637			72
73	Drugs Charged to Patients		1,972,844			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		2,450,297			88
90	Clinic		358,618			90
90.01	SALEM MEDICAL CLINIC					90.01
91	Emergency		3,411,199			91
92	Observation Beds (Non-Distinct Part)		350,905	450,315	0.779243	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	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		19,648,498	450,315		200
201	Less Observation Beds		350,905	450,315		201
202	Total		19,297,593			202

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.593895		1,475,888			876,523		50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.369398		2,026,307			748,514		54
57	CT Scan	0.059001		4,278,999			252,465		57
58	MRI	0.296074		652,121			193,076		58
60	Laboratory	0.216165		3,861,895			834,807		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.248277		755,314			187,527		65
66	Physical Therapy	0.343544		890,736			306,007		66
69	Electrocardiology	0.294077		318,840			93,764		69
71	Medical Supplies Charged to Pat	0.431113		363,950			156,904		71
72	Impl. Dev. Charged to Patients	0.811256		109,536			88,862		72
73	Drugs Charged to Patients	0.793380		968,174			768,130		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.724367		219,028			158,657		90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.710167		1,555,015			1,104,320		91
92	Observation Beds (Non-Distinct	0.779243		124,286			96,849		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			17,600,089			5,866,405		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			17,600,089			5,866,405		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.593895							50
53	Anesthesiology								53
54	Radiology-Diagnostic	0.369398							54
57	CT Scan	0.059001							57
58	MRI	0.296074							58
60	Laboratory	0.216165							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.248277							65
66	Physical Therapy	0.343544							66
69	Electrocardiology	0.294077							69
71	Medical Supplies Charged to Pat	0.431113							71
72	Impl. Dev. Charged to Patients	0.811256							72
73	Drugs Charged to Patients	0.793380							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.724367							90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency	0.710167							91
92	Observation Beds (Non-Distinct	0.779243							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	695,081	221,636	473,445	1,975	239.72	118	28,287	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)	695,081		473,445	1,975		118	28,287	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1345

WORKSHEET D PART II

Check ☐ Title V ☒ Hospital ☐ SUB (Other)
 Applicable ☐ Title XVIII, Part A ☐ IPF
 Boxes: ☒ Title XIX ☐ IRF

		Capital Related Cost (from Wkst. B, Part II (col. 26)	Total Charges (from Wkst. C, Part I, (col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	395,395	3,321,008	0.119059	11,325	1,348	50
53	Anesthesiology						53
54	Radiology-Diagnostic	369,672	5,306,253	0.069667	6,099	425	54
57	CT Scan	166,093	10,143,658	0.016374	13,330	218	57
58	MRI	323,623	1,739,874	0.186004			58
60	Laboratory	267,496	13,839,922	0.019328	21,374	413	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	126,358	3,550,349	0.035590	12,353	440	65
66	Physical Therapy	138,948	2,848,200	0.048784	2,838	138	66
69	Electrocardiology	27,265	665,081	0.040995	177	7	69
71	Medical Supplies Charged to Pat	33,729	1,228,629	0.027453	3,140	86	71
72	Impl. Dev. Charged to Patients	10,922	593,693	0.018397	5,863	108	72
73	Drugs Charged to Patients	138,350	2,486,633	0.055637	16,532	920	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	175,454	1,540,923	0.113863			88
90	Clinic	71,143	495,078	0.143701			90
90.01	SALEM MEDICAL CLINIC						90.01
91	Emergency	196,658	4,803,378	0.040942	939	38	91
92	Observation Beds (Non-Distinct	56,814	450,315	0.126165			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	2,497,920	53,012,994		93,970	4,141	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	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

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,975		118		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)	1,975		118		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
50	Operating Room									50
53	Anesthesiology									53
54	Radiology-Diagnostic									54
57	CT Scan									57
58	MRI									58
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room				11,325				50
53	Anesthesiology								53
54	Radiology-Diagnostic				6,099				54
57	CT Scan				13,330				57
58	MRI								58
60	Laboratory				21,374				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy				12,353				65
66	Physical Therapy				2,838				66
69	Electrocardiology				177				69
71	Medical Supplies Charged to Pat				3,140				71
72	Impl. Dev. Charged to Patients				5,863				72
73	Drugs Charged to Patients				16,532				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				939				91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)				93,970				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1345

WORKSHEET D
PART V

Check [] Title V - O/P [XX] Hospital [] SUB (Other) [] Swing Bed SNF
Applicable [] Title XVIII, Part B [] IPF [] SNF [] Swing Bed NF
Boxes: [XX] Title XIX - O/P [] IRF [] NF [] ICF/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.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room			306					50
53	Anesthesiology								53
54	Radiology-Diagnostic			127,510					54
57	CT Scan			310,180					57
58	MRI			35,514					58
60	Laboratory			371,844					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy			23,595					65
66	Physical Therapy			56,118					66
69	Electrocardiology			11,369					69
71	Medical Supplies Charged to Pat			14,196					71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients			20,173					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			35,105					90
90.01	SALEM MEDICAL CLINIC								90.01
91	Emergency			344,745					91
92	Observation Beds (Non-Distinct			37,719					92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			1,388,374					200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			1,388,374					202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1345****WORKSHEET D-1
PART I**

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 I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,906	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,975	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)	1,738	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	693	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)	231	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	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)	2	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,210	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)	664	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)	222	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)	4,293,117	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)	603	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	241	25
26	Total swing-bed cost (see instructions)	1,368,918	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,924,199	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,924,199	37

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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							1
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,480.60 38
39	Program general inpatient routine service cost (line 9 x line 38)						1,791,526 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)						1,791,526 41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47
							1
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1,504,175 48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						3,295,701 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)						983,118 64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						328,693 65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						1,311,811 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

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					237	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,480.61	88
89	Observation bed cost (line 87 x line 88) (see instructions)					350,905	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	695,081	4,293,117	0.161906	350,905	56,814	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1345****WORKSHEET D-1
PART I**

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 I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,906	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,975	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)	1,738	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	693	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)	231	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	5	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)	2	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	118	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)	4,293,117	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)	603	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	241	25
26	Total swing-bed cost (see instructions)	1,368,918	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,924,199	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 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,924,199	37

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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							1	
38	Adjusted general inpatient routine service cost per diem (see instructions)						1,480.60	38
39	Program general inpatient routine service cost (line 9 x line 38)						174,711	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)						174,711	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)						174,711	49
PASS THROUGH COST ADJUSTMENTS								
50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						28,287	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						4,141	51
52	Total Program excludable cost (sum of lines 50 and 51)						32,428	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

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1345

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					237	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,480.61	88
89	Observation bed cost (line 87 x line 88) (see instructions)					350,905	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	695,081	4,293,117	0.161906	350,905	56,814	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,930,079		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.593895	311,768	185,157	50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.369398	185,428	68,497	54
57	CT Scan	0.059001	244,545	14,428	57
58	MRI	0.296074	22,595	6,690	58
60	Laboratory	0.216165	689,829	149,117	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.248277	1,190,796	295,647	65
66	Physical Therapy	0.343544	94,693	32,531	66
69	Electrocardiology	0.294077	10,556	3,104	69
71	Medical Supplies Charged to Patients	0.431113	228,066	98,322	71
72	Impl. Dev. Charged to Patients	0.811256	340,575	276,294	72
73	Drugs Charged to Patients	0.793380	471,388	373,990	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.724367	549	398	90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.710167			91
92	Observation Beds (Non-Distinct Part)	0.779243			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		3,790,788	1,504,175	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		3,790,788		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.593895			50
53	Anesthesiology				53
54	Radiology-Diagnostic	0.369398	28,468	10,516	54
57	CT Scan	0.059001	19,226	1,134	57
58	MRI	0.296074			58
60	Laboratory	0.216165	152,540	32,974	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.248277	270,415	67,138	65
66	Physical Therapy	0.343544	592,751	203,636	66
69	Electrocardiology	0.294077	1,738	511	69
71	Medical Supplies Charged to Patients	0.431113	1,420	612	71
72	Impl. Dev. Charged to Patients	0.811256			72
73	Drugs Charged to Patients	0.793380	114,199	90,603	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.724367			90
90.01	SALEM MEDICAL CLINIC				90.01
91	Emergency	0.710167			91
92	Observation Beds (Non-Distinct Part)	0.779243			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,180,757	407,124	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,180,757		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		23,463		30
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room		11,325		50
53	Anesthesiology				53
54	Radiology-Diagnostic		6,099		54
57	CT Scan		13,330		57
58	MRI				58
60	Laboratory		21,374		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy		12,353		65
66	Physical Therapy		2,838		66
69	Electrocardiology		177		69
71	Medical Supplies Charged to Patients		3,140		71
72	Impl. Dev. Charged to Patients		5,863		72
73	Drugs Charged to Patients		16,532		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		939		91
92	Observation Beds (Non-Distinct Part)				92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		93,970		200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		93,970		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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)	5,866,405			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, 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)	5,866,405			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 (see instructions)	5,925,069			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, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	47,998			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	2,778,205			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)	3,098,866			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)	3,098,866			30
31	Primary payer payments	3,256			31
32	Subtotal (line 30 minus line 31)	3,095,610			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)	538,717			34
35	Adjusted reimbursable bad debts (see instructions)	350,166			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	287,187			36
37	Subtotal (see instructions)	3,445,776			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)	3,445,776			40
40.01	Sequestration adjustment (see instructions)	68,916			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	4,063,551			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-686,691			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

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			2,668,472		3,978,917
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					
3	List separately each retroactive lump sum adjustment	.01			09/24/2018	61,634
	amount based on subsequent revision of the interim	.02	11/01/2018	261,510	11/01/2018	19,376
	rate for the cost reporting period. Also show date of	.03			02/06/2019	3,624
	each payment. If none, write 'NONE' or enter a zero. (1)	.04				
	Program	.05				
	to	.06				
	Provider	.07				
		.08				
		.09				
		.10				
		.50				
		.51	02/06/2019	57,985		
	Provider	.52				
	to	.53				
	Program	.54				
		.55				
		.56				
		.57				
		.58				
		.59				
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		203,525		84,634
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)			2,871,997		4,063,551
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment	.01				5.01
	after desk review. Also show date of each payment.	.02				5.02
	If none, write 'NONE' or enter a zero. (1)	.03				5.03
	Program	.04				5.04
	to	.05				5.05
	Provider	.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due)	.01		124,012		6.01
	based on the cost report (1)	.02				-686,691
7	Total Medicare program liability (see instructions)			2,996,009		3,376,860
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			1,754,140		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment	.01	09/24/2018	66,688		3.01
	amount based on subsequent revision of the interim	.02	11/01/2018	38,806		3.02
	rate for the cost reporting period. Also show date of	Program	.03	02/06/2019	1,150	3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51			3.51
		Provider	.52			3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		106,644		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)			1,860,784		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment	.01				5.01
	after desk review. Also show date of each payment.	.02				5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due)	.01				6.01
	based on the cost report (1)	.02		-175,684		6.02
7	Total Medicare program liability (see instructions)			1,685,100		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.

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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)	1,324,929		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)	411,195		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	886		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)	1,736,124		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,736,124		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,736,124		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	16,634		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)	1,719,490		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)	1,719,490		19
19.01	Sequestration adjustment (see instructions)	34,390		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	1,860,784		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	-175,684		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

KPMG LLP Compu-Max 2552-10

SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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CALCULATION OF REIMBURSEMENT SETTLEMENT**WORKSHEET E-3
PART V****PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT**

1	Inpatient services	3,295,701	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	3,295,701	4
5	Primary payer payments	454	5
6	Total cost (see instructions)	3,328,204	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	3,328,204	19
20	Deductibles (exclude professional component)	318,812	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	3,009,392	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	3,009,392	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	73,477	25
26	Adjusted reimbursable bad debts (see instructions)	47,760	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,175	27
28	Subtotal (sum of lines 24 and 26)	3,057,152	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	3,057,152	30
30.01	Sequestration adjustment (see instructions)	61,143	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	2,871,997	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	124,012	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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	174,711		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	174,711		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	174,711		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges	93,970	1,388,374	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)	93,970	1,388,374	12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)	93,970	1,388,374	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)	174,711		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)	174,711		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)	174,711		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)	174,711		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	174,711		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)	174,711		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	174,711		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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	4,425,608				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	8,529,134				4
5	Other receivables	274,050				5
6	Allowances for uncollectible notes and accounts receivable	-4,290,000				6
7	Inventory	439,591				7
8	Prepaid expenses	363,550				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	9,741,933				11
	FIXED ASSETS					
12	Land	203,353				12
13	Land improvements	1,180,058				13
14	Accumulated depreciation	-904,827				14
15	Buildings	35,138,155				15
16	Accumulated depreciation	-13,243,709				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment	2,790,939				19
20	Accumulated depreciation	-1,622,893				20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	11,169,472				23
24	Accumulated depreciation	-8,668,459				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)	26,042,089				30
	OTHER ASSETS					
31	Investments	2,017,255				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)	2,017,255				35
36	Total assets (sum of lines 11, 30 and 35)	37,801,277				36
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	Liabilities and Fund Balances (Omit Cents)	1	2	3	4	
	CURRENT LIABILITIES					
37	Accounts payable	1,052,325				37
38	Salaries, wages and fees payable	1,109,905				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	685,090				40
41	Deferred income					41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	1,375,028				44
45	Total current liabilities (sum of lines 37 thru 44)	4,222,348				45
	LONG TERM LIABILITIES					
46	Mortgage payable	14,887,500				46
47	Notes payable	1,916,994				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	16,804,494				50
51	Total liabilities (sum of lines 45 and 50)	21,026,842				51
	CAPITAL ACCOUNTS					
52	General fund balance	16,774,435				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)	16,774,435				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	37,801,277				60

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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		18,266,687		1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,492,252		2
3	Total (sum of line 1 and line 2)		16,774,435		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)		16,774,435		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)		16,774,435		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

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	3,615,893		3,615,893	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	2,718,173		2,718,173	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)	6,334,066		6,334,066	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)	6,334,066		6,334,066	17
18	Ancillary services	5,401,853	39,090,600	44,492,453	18
19	Outpatient services		6,150,458	6,150,458	19
20	Rural Health Clinic (RHC)		1,545,943	1,545,943	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		1,212,973	1,212,973	27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	11,735,919	47,999,974	59,735,893	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		28,396,897	29
30	Add (specify)			30
31	LOSS ON SALE OF ASSETS	9,145		31
32	340B EXPENSE	430,701		32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)		439,846	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)		28,836,743	43

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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STATEMENT OF REVENUES AND EXPENSES**WORKSHEET G-3**

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	59,735,893	1
2	Less contractual allowances and discounts on patients' accounts	33,147,255	2
3	Net patient revenues (line 1 minus line 2)	26,588,638	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	28,836,743	4
5	Net income from service to patients (line 3 minus line 4)	-2,248,105	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	122,774	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		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	125,562	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	79,721	20
21	Rental of vending machines		21
22	Rental of hosptial space	94,620	22
23	Governmental appropriations		23
24	Other (PROPERTY TAX REVENUE)	258,105	24
24.01	Other (340(B) NET REVENUE)		24.01
24.02	Other (GAIN ON SALE OF ASSETS)		24.02
24.03	Other (GRANT REVENUE)	74,735	24.03
24.04	Other (OTHER MISCELLANEOUS REVENUE)	336	24.04
25	Total other income (sum of lines 6-24)	755,853	25
26	Total (line 5 plus line 25)	-1,492,252	26
29	Net income (or loss) for the period (line 26 minus line 28)	-1,492,252	29

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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
192.03	RISE OUTREACH LAB							192.03
194	LITIGATION COSTS							194
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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**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	561,519	33,163	594,682	-176,570	418,112		418,112	1
2	Physician Assistant								2
3	Nurse Practitioner	399,867	131,966	531,833		531,833		531,833	3
4	Visiting Nurse								4
5	Other Nurse	272,783	16,110	288,893		288,893		288,893	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)	1,234,169	181,239	1,415,408	-176,570	1,238,838		1,238,838	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		62,685	62,685		62,685		62,685	11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)		62,685	62,685		62,685		62,685	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		1,145	1,145		1,145		1,145	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)		1,145	1,145		1,145		1,145	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,234,169	245,069	1,479,238	-176,570	1,302,668		1,302,668	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs	152,000	77,660	229,660	-18,968	210,692		210,692	30
31	Total Facility Overhead (sum of lines 29 and 30)	152,000	77,660	229,660	-18,968	210,692		210,692	31
32	Total facility costs (sum of lines 22, 28 and 31)	1,386,169	322,729	1,708,898	-195,538	1,513,360		1,513,360	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.

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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	0.53	2,514	4,200	2,226		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	2.85	8,964	2,100	5,985		3
4	Subtotal (sum of lines 1 through 3)	3.38	11,478		8,211	11,478	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)	3.38	11,478			11,478	8
9	Physician Services Under Agreements		213			213	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,302,668	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,302,668	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)	210,692	14
15	Parent provider overhead allocated to facility (see instructions)	936,937	15
16	Total overhead (sum of lines 14 and 15)	1,147,629	16
17	Allowable Direct GME overhead (see instructions)		17
18	Subtotal (see instructions)	1,147,629	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,147,629	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)	2,450,297	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.

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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)	2,450,297	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	67,780	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,382,517	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	11,478	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	213	5
6	Total adjusted visits (line 4 plus line 5)	11,691	6
7	Adjusted cost per visit (line 3 divided by line 6)	203.79	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)	203.79	203.79	203.79	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		1,929		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		393,111		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)		393,111		16
16.01	Total program charges (see instructions)(from contractor's records)		273,627		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)		290,376		16.04
16.05	Total program cost (see instructions)		290,376		16.05
17	Primary payer payments		22		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		30,141		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		48,697		19
20	Net Medicare cost excluding vaccines (see instructions)		290,354		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		49,005		21
22	Total reimbursable Program cost (line 20 plus line 21)		339,359		22
23	Allowable bad debts (see instructions)		5,100		23
23.01	Adjusted reimbursable bad debts (see instructions)		3,315		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,100		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		342,674		26
26.01	Sequestration adjustment (see instructions)		6,853		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		247,503		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		88,318		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.

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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)	1,238,838	1,238,838	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000614	0.001584	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	761	1,962	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	22,478	10,833	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	23,239	12,795	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,302,668	1,302,668	6
7	Total overhead (from Wkst. M-2, line 16)	1,147,629	1,147,629	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.017840	0.009822	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	20,474	11,272	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	43,713	24,067	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	154	226	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	283.85	106.49	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	125	127	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	35,481	13,524	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)		67,780	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)		49,005	16

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SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345	In Lieu of Form CMS-2552-10	Period : From: 04/01/2018 To: 03/31/2019	Run Date: 08/30/2019 Run Time: 11:41 Version: 2018.12 (06/06/2019)
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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 1	Amount 2	
1	Total interim payments paid to provider			232,517	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)		11/01/2018	14,986	3.01
		.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			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		14,986	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)			247,503	
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		88,318	6.01
		.02			6.02
7	Total Medicare program liability (see instructions)			335,821	
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.