Health Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g: 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 14-1345

AND SETTLEMENT SUMMARY

Period: From 04/01/2022 From 04/01/2022 To 03/31/2023 Date/Time Prepared:

				10 03/31/2023		
					8/29/2023 9): 20 am
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepared	pared cost report		Date: 8/29/20	23 Time:	9: 20 am
use only	2. [] Manually prepared of	cost report				
	3. [0] If this is an amend 4. [F] Medicare Utilization	ded report enter the number on. Enter "F" for full, "L'	of times the provider r ' for low, or "N" for no	resubmitted this o o.	ost report	
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audi (3) Settled with Audit (4) Reopened (5) Amended		11. C or this Provider CCN 12.[NPR Date: Contractor's Vendo [O]If line 5, co number of tim	lumn 1 is 4	

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SALEM TOWNSHIP HOSPITAL (14-1345) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1		2	SIGNATURE STATEMENT	
1	Alex	Nazarian	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Alex Nazarian			2
3	Signatory Title	CEO CEO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-533, 240	-2, 357, 408	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	96, 495	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		28, 476		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-32, 201		0	10. 01
200.00	TOTAL	0	-436, 745	-2, 361, 133	0	0	200.00

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the 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.

Heal th Financial Systems SALEM TOWNSHIP HOSPITAL
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1345
From 04/01/2022
From 04/01/2022
To 03/31/2023
Date/Time Prepared:

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	I DENTI FI (CATION DATA	Provi d	ler CO	CN: 14-1		Period: From 04/01/ To 03/31/	2022	Workshe Part I Date/Ti		
										8/29/20		
	1.00	1 - · · · A -l	2. 00		3. 00)			1. 00			
1. 00	Hospital and Hospital Health Care Co Street: 1201 RICKER DRIVE	omprex Ad	PO Box:									1.00
2. 00	City: SALEM		State: IL	Zip Code	e: 628	881	Count	y: MARION				2.00
	, <u>-</u> ,		oonent Name	CCN			ovi der		Paymei	nt Syst	em (P,	
				Number	Num	ber '	Type	Certi fi ed		0, or		
			1.00	0.00		-			V	XVIII		_
	Hospital and Hospital-Based Componer	at Idonti	1.00	2. 00	3.	00	4. 00	5. 00	6. 00	7.00	8. 00	
3. 00	Hospi tal		WNSHIP HOSPITAL	141345	999	914	1	07/01/1966	N	0	0	3.00
4. 00	Subprovi der - IPF	07122 10			'''	,	•					4.00
5.00	Subprovi der - IRF											5.00
6.00	Subprovider - (Other)											6.00
7. 00	Swing Beds - SNF	SALEM S/	B SNF	14Z345	999	914		12/17/1986	N	0	N	7.00
8.00	Swing Beds - NF											8.00
9. 00 10. 00	Hospi tal -Based SNF Hospi tal -Based NF											9.00
	Hospi tal -Based OLTC											11.00
	Hospi tal -Based HHA											12.00
	Separately Certified ASC											13.00
	Hospi tal -Based Hospi ce											14.00
15.00	Hospital-Based Health Clinic - RHC	STH RURA	L HEALTH CLINIC	143413	999	914		07/29/1996	N	0	N	15.00
15. 01	Hospital-Based Health Clinic - RHC	STH RURU	AL HEALTH	148608	999	914		01/30/2020	N	0	N	15. 01
	[1]	CLINIC -	FHCC									
	Hospital -Based Health Clinic - FQHC											16.00
	Hospital -Based (CMHC) I											17.00
19.00	Renal Dialysis											19.00
17.00	jo trici							From:		To	:	17.00
								1. 00		2. (
	Cost Reporting Period (mm/dd/yyyy)							04/01/2	022	03/31/	/2023	20.00
21. 00	Type of Control (see instructions)							12				21.00
						1	00	2. 00		3. (20	-
	Inpatient PPS Information							2.00		0. (,,,	
22.00	Does this facility qualify and is it	current	ly receiving pay	ments fo	r		N	N				22.00
	disproportionate share hospital adju				R							
	§412.106? In column 1, enter "Y" fo											
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for			enament								
22. 01	Did this hospital receive interim UC			tal IICPs	for		N	N				22. 01
22.01	this cost reporting period? Enter in						. •					22.01
	for the portion of the cost reportir											
	1. Enter in column 2, "Y" for yes or			tion of t	he							
	cost reporting period occurring on o	or after	October 1. (see									
00.00	instructions)		6' 1 100 1									00.00
22. 02	Is this a newly merged hospital that determined at cost report settlement	•			Lump		N	N				22. 02
	1, "Y" for yes or "N" for no, for the				ı uılırı							
	period prior to October 1. Enter in				no.							
	for the portion of the cost reportir				,							
22.03	Did this hospital receive a geograph				0		N	N		N		22. 03
	rural as a result of the OMB standar											
	adopted by CMS in FY2015? Enter in c											
	for the portion of the cost reporting	J 1	•		er							
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft											
	Does this hospital contain at least				as							
	counted in accordance with 42 CFR 41											
	yes or "N" for no.	,										
22. 04	Did this hospital receive a geograph											22. 04
	rural as a result of the revised OME											
	adopted by CMS in FY 2021? Enter in											
	for the portion of the cost reportir in column 2, "Y" for yes or "N" for				C1							
	reporting period occurring on or after October 1. (see instructions)											
	Does this hospital contain at least				as							
	counted in accordance with 42 CFR 41											
	yes or "N" for no.			.,	_							
23. 00	Which method is used to determine Medicaid days on lines 24 and/or 25 2 N 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3											
	if date of discharge. Is the method											
					JJJ 1	1						1
	reporting period different from the	method u	sed in the prior	COST								
	eporting period? In column 2, enter "Y" for yes or "N" for no.											

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1345 Peri od: Worksheet S-2 From 04/01/2022 Part I 03/31/2023 Date/Time Prepared: 8/29/2023 9: 20 am 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	SALEM	TOWNSHIP HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 04/01/2022	Worksheet S-2 Part I Date/Time Pre	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	8/29/2023 9: 2 Ratio (col. 1/ (col. 1 + col. 2))	o am
Section 5504 of the ACA Base Yea	ar FTF Pasidents in N	onnrovider Settings-	1.00	2.00	3.00	
period that begins on or after			- IIII 3 base year	- 13 your cost	r epor triig	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)	nber of unweighted nor etations occurring in e number of unweighted our hospital. Enter in	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
(5.00 5.1 1.0	1. 00	2. 00	3.00	4. 00	5. 00	/F 00
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)			0.00	0.00	0.000000 Ratio (col.	65. 00
			FTEs	FTEs in	1/ (col. 1 +	
			Nonprovi der Si te	Hospi tal	col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima occurring in all nonpo unweighted non-prima cal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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)			0.00	0.00	0. 000000	67.00

	Financial Systems SALEM TOWNSHIP HOSPITAL				Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO	CN: 14-1345	Peri od: From 04/01/20 To 03/31/20	D22 Par D23 Date	ksheet S-2 t I e/Time Pro 9/2023 9:2	epared:
	·				1. 00	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-44 For a cost reporting period beginning prior to October 1, 2022, did you om MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fir (August 10, 2022)?	btain permis	sion from you		N	68. 00
				1.00 2.	00 3.00	
	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it cont	ain an IPF s	ubprovi der?	N		70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachi recent cost report filed on or before November 15, 2004? Enter "Y" for y 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for y Column 3: If column 2 is Y, indicate which program year began during this (see instructions) Inpatient Rehabilitation Facility PPS	ves or "N" fo s in a new te ves or "N" fo	r no. (see achi ng r no.		0	71.00
	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it of subprovider? Enter "Y" for yes and "N" for no.	contain an IR	F	N		75. 00
76. 00	If line 75 is yes: Column 1: Did the facility have an approved GME teachi recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see	"Y" for yes nin accordan column 2 is	or "N" for ce with 42 Y,		0	76.00
					1. 00	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no.		ng period? En	ter	N N	80. 00 81. 00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			no.	N	85. 00 86. 00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under sectio	n		N	87. 00
	Trood(u)(T)(b)(vi): Litter T Tor yes of N Tor No.		Approved f Permanent Adjustmen (Y/N) 1.00	t A	umber of oproved ermanent ustments 2.00	-
	Column 1: Is this hospital approved for a permanent adjustment to the TEF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete of 89. (see instructions)		ne		(88.00
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Lin	e Effective	e A	oproved	
		No.	Date	Pe Adj Am	ermanent justment ount Per scharge	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00		3. 00	89.00
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.				·	7 07.00
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.					
			V 1.00		XI X 2. 00	
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? E	nter "Y" for	N		Υ	90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report State Sta		N		Υ	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column Are title XIX NF patients occupying title XVIII SNF beds (dual certificat				N	92.00
93. 00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V ar "Y" for yes or "N" for no in the applicable column.	nd XIX? Enter	N		N	93. 00
94. 00	operative or Notional the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for rapplicable column.	no in the	N		N	94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable colum Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for r applicable column.		0. 00 N		0. 00 N	95. 00 96. 00
97. 00	lf line 96 is "Y", enter the reduction percentage in the applicable colum	ın.	0. 00		0. 00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 14-1345	Peri od: From 04/01/2022 To 03/31/2023	Date/Time Pr	epared:
			V	8/29/2023 9: XI X	20 am
			1.00	2.00	1
98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.			N	N	98.00
98.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				Y	98.01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o			N	N	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye				N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N d	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				N	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	N	98.06
Rural Providers 105.00Does this hospital qualify as a CAH?			Υ		105.00
106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		. ,	nt Y		106.00
107.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP	1. (see ins you train I&R F and/or IRF	structions) Rs in an	N		107.00
Enter "Y" for yes or "N" for no in column 2. (see instructi 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche				108.00
	Physi cal 1. 00	Occupationa 2.00	Speech 3.00	Respiratory 4.00	_
109.00 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 no for each therapy.	Y	Y	Y	N	109.00
				1.00	4
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "			84104	1.00	- 1
complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.			If yes,	N	110.00
complete Worksheet E, Part A, lines 200 through 218, and Wor			If yes, ough 215, as		110.00
complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	he Frontier C st reporting lumn 1 is Y, ticipating in	community period? Ente enter the column 2.	1.00 N	N 2.00	110.00
complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. 111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad	he Frontier C st reporting lumn 1 is Y, ticipating in	Community period? Ente enter the column 2. c; and/or "C"	If yes, ough 215, as	2.00	
complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this compared in the property of the FCHIP demonstration for this compared in the property of the FCHIP demonstration for the participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost respectively.	he Frontier C st reporting lumn 1 is Y, ticipating in ditional beds th Model porting lumn 1 is ating in the	community period? Ente enter the column 2.	1.00 N		
complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this compared in the response to	he Frontier C st reporting lumn 1 is Y, ticipating in ditional beds th Model porting lumn 1 is ating in the	community period? Ente enter the column 2. ;; and/or "C"	If yes, ough 215, as	2.00	111.00
complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the response to the r	he Frontier C st reporting lumn 1 is Y, ticipating ir ditional beds th Model porting lumn 1 is ating in the sed "N" for no , or E only) 3" percent includes	community period? Ente enter the column 2. ;; and/or "C"	If yes, ough 215, as	2.00	111.00
complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this converse integration prong of the FCHIP demonstration for this CAH is participate all that apply: "A" for Ambulance services; "B" for ad for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost respective period? Enter "Y" for yes or "N" for no in column 1. If converse in column 2, the date the hospital began participed demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	he Frontier C st reporting lumn 1 is Y, ticipating in ditional beds th Model porting lumn 1 is ating in the sed "N" for no , or E only) 3" percent includes s) based on	community period? Ente enter the column 2. ; and/or "C"	If yes, ough 215, as	2.00	111.00
complete Worksheet E, Part A, lines 200 through 218, and Worapplicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the FCHIP demonstration for this compared by the FCHIP demonstration for this CAH is participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost respensed? Enter "Y" for yes or "N" for no in column 1. If compared by the formulation of the date the hospital began participated by the date the hospital began participated by the date the hospital comparticipation. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider).	he Frontier C st reporting lumn 1 is Y, ticipating in ditional beds th Model porting lumn 1 is ating in the sed ""N" for no , or E only) 3" percent includes s) based on	ines 200 thr Community period? Ente enter the column 2. ; and/or "C" 1.00 N	If yes, ough 215, as	2.00	111.00

Health Financial Systems	SALEM TOWNSHIP I				u of Form CM	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	IFICATION DATA	Provi der CCM	I: 14-1345	Period: From 04/01/2022 To 03/31/2023	Worksheet S Part I Date/Time F	Prepared:
			Premi ums	Losses	8/29/2023 9 Insurance	
118.01 List amounts of mal practice premiums and	naid Losses:		1. 00 104, 5	2. 00	3. 00	0118.01
110. Office of amounts of mar practice promitants and	para 1033c3.		101, 0			0110.01
118.02 Are mal practice premiums and paid losses	reported in a cost co	enter other t	han the	1. 00 Y	2. 00	118. 02
Administrative and General? If yes, submand amounts contained therein. 119.00D0 NOT USE THIS LINE	nit supporting schedul	e listing co	st centers	·		119.00
120.00 Is this a SCH or EACH that qualifies for \$3121 and applicable amendments? (see ins "N" for no. Is this a rural hospital with Hold Harmless provision in ACA §3121 and Enter in column 2, "Y" for yes or "N" for	structions) Enter in on a control of the control of	column 1, "Y" ifies for th	for yes or e Outpatien	,	N	120.00
121.00 Did this facility incur and report costs	for high cost implant	table devices	charged to	Y Y		121. 00
patients? Enter "Y" for yes or "N" for no 122.00 Does the cost report contain healthcare r Act?Enter "Y" for yes or "N" for no in co	related taxes as defir blumn 1. If column 1 i					122. 00
the Worksheet A line number where these t 123.00Did the facility and/or its subproviders services, e.g., legal, accounting, tax pr management/consulting services, from an u for yes or "N" for no.	(if applicable) purch reparation, bookkeepin	ng, payroll,	and/or	71		123. 00
If column 1 is "Y", were the majority of professional services expenses, for servilocated in a CBSA outside of the main hos "N" for no.	ces purchased from ur	nrelated orga	ni zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-cer	rtified transplant cer	nter? Enter "	Y" for ves	N		125. 00
and "N" for no. If yes, enter certificati	on date(s) (mm/dd/yyy	yy) below.	,			
126.00 If this is a Medicare-certified kidney tr in column 1 and termination date, if appl		ter the certi	rication da	ite		126. 00
127.00 If this is a Medicare-certified heart tra in column 1 and termination date, if appl	ansplant program, ente	er the certif	ication dat	e		127. 00
128.00 If this is a Medicare-certified liver tra	ansplant program, ente	er the certif	ication dat	е		128. 00
in column 1 and termination date, if appl 129.00 If this is a Medicare-certified lung tran		the certifi	cation date	,		129. 00
in column 1 and termination date, if appl	icable, in column 2.					
130.00 If this is a Medicare-certified pancreas date in column 1 and termination date, if			tification			130. 00
131.00 If this is a Medicare-certified intestina date in column 1 and termination date, if			erti fi cati o	on		131. 00
132.00 If this is a Medicare-certified islet tra in column 1 and termination date, if appl	ansplant program, ente		ication dat	e		132. 00
133.00 Removed and reserved 134.00 If this is a hospital-based organ procure in column 1 and termination date, if appl		PO), enter th	e OPO numbe	er		133. 00 134. 00
All Providers 140.00 Are there any related organization or hom	no offico costs as dot	Finad in CMS	Dub 15 1	N	T	140. 00
chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home of	no in column 1. If ye office chain number. (es, and home	office cost	s		140.00
1.00 If this facility is part of a chain organ	2.00 nization, enter on lii	nes 141 throu	igh 143 the	3.00 name and address	of the home	9
office and enter the home office contract	tor name and contracto					
	ntractor's Name: Box:		Contract	or's Number:		141. 00 142. 00
1	ate:		Zi p Code) :		143. 00
					1.00	
144.00 Are provider based physicians' costs incl	uded in Worksheet A?				Y	144.00
				1. 00	2. 00	
145.00 If costs for renal services are claimed of inpatient services only? Enter "Y" for yearno, does the dialysis facility include Me period? Enter "Y" for yes or "N" for no	es or "N" for no in co edicare utilization fo	olumn 1. If o	olumn 1 is			145. 00
146.00 Has the cost allocation methodology change Enter "Y" for yes or "N" for no in column lyes, enter the approval date (mm/dd/yyyy)	ged from the previousI n 1. (See CMS Pub. 15-			f N		146. 00

Health Financial Systems	SALEM TOV					I	n Lie	u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	4	Provi der CC	CN: 14-1345		riod: om 04/01 03/31	/2022 /2023		epared:
								1.00	_
147.00 Was there a change in the statist	ical basis? Enter "Y"	for ves	s or "N" for	no.				1.00 N	147.00
148.00 Was there a change in the order o								N	148.00
149.00 Was there a change to the simplif	ied cost finding metho	od? Ente	er "Y" for y	es or "N"	for r			N	149.00
			Part A	Part		Titl∈		Title XIX	
			1.00	2.00		3. 0		4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or									
155. 00 Hospi tal			Υ	Y		N		N	155. 00
156.00 Subprovi der - IPF			N	N		N		N	156. 00
157. 00 Subprovi der - IRF			N	N N		N		N	157. 00
158. 00 SUBPROVI DER									158. 00
159. 00 SNF			N	N N		N		N	159.00
160.00 HOME HEALTH AGENCY			N	N N		N		N N	160.00
161. 00 CMHC				N N		N		N	161. 00
								1.00	
Mul ti campus								1	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one o	or more camp	uses in di	ffere	ent CBSAs	s?	N	165.00
	Name		County	State	Zip (Code	BSA	FTE/Campus	
	0		1. 00	2. 00	3. (00 4	1. 00	5. 00	
166.00 f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0 166. 00
								1. 00	-
Health Information Technology (HI	T) incentive in the Ar	meri can	Recovery ar	nd Rei nves	tment	Act		1.00	
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1						ontor th	10	Y	167. 00 168. 00
reasonable cost incurred for the				e 107 13	١),	enter ti	ic		100.00
168. 01 If this provider is a CAH and is		,	,	r qualify	for a	nardshi	р		168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful						√, ente	er the	0.0	 0169.00
transition factor. (see instructi	ons)								
						Begi nr		Endi ng	
170 00 5-1 1 1 2 510		d:				1. 0	Ü	2. 00	170.00
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	uing da	te for the r	eporting					170.00
					-	1. 0	0	2.00	
171.00 If line 167 is "Y", does this pro	vider have any davs fo	or indiv	vi dual s enro	lled in		N	-		0171.00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is	, Pt. I,	, line 2, co	I. 6? Ente					

Health Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1345 Peri od: Worksheet S-2 From 04/01/2022 Part II Date/Time Prepared: 03/31/2023 8/29/2023 9:20 am Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE 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 Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 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) Was the cost report prepared using the PS&R Report for 17.00 Υ 06/27/2023 Υ 06/27/2023 17.00 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) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 14-1345	Peri od: From 04/01/2022 To 03/31/2023	Worksheet S Part II	S-2 Prepared:
			i pti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			İN	IN	20.00
	100	Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se			ing the cost	N	22.00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprai	sais made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases enter lf yes, see instructions	ed into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repo	rting period?	Plf yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period? I	f yes, see	N	26.00
27. 00	instructions. Has the provider's capitalization policy changed during th	ne cost reporti	na neriod? If	ves submit	N	27. 00
27.00	сору.		g por rour rr	, , , , , , , , , , , , , , , , , , ,		
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or Letters of credit e</pre>	entered into du	ring the cost	reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service R	Reserve Fund)	Υ	29. 00
	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	ructions		,	N	
30. 00	instructions.	,	,			30.00
31. 00	Has debt been recalled before scheduled maturity without instructions.	ssuance of new	debt? If yes	s, see	N	31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If	N	33. 00
	no, see instructions. Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-b	pased physicians?	Y	34.00
35 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	ristina aareeme	nts with the	nrovi der-hased	N	35. 00
	physicians during the cost reporting period? If yes, see i					33.00
				Y/N 1. 00	2.00	
	Home Office Costs			1.00	2.00	
36.00	Were home office costs claimed on the cost report?			N		36.00
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	P N		37.00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			• N		38. 00
39. 00				s, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
	i nstructi ons.					
		00				
41 00	Cost Report Preparer Contact Information	DAVID		COODMAN		44.00
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVI D		GOODMAN		41.00
42. 00	Enter the employer/company name of the cost report	WI PFLI				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	608-270-2960		DGOODMAN@WI PFL	I. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Health Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu of						u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL	HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der		Peri od: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part II Date/Time Pre 8/29/2023 9:2	pared:
				3. 00			
Cost Report Pre	eparer Contact Information			5. 00			
41.00 Enter the firs	t name, last name and the t st report preparer in colum		СРА				41. 00
	oyer/company name of the co	ost report					42. 00
43.00 Enter the tele	phone number and email addr r in columns 1 and 2, respo						43. 00

 Health Financial
 Systems
 SALEM T

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 In Lieu of Form CMS-2552-10 SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345

				'	0 03/31/2023	8/29/2023 9: 20	
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	Title V	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA				1		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	41, 064. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7. 00	Total Adults and Peds. (exclude observation		25	9, 125	41, 064. 00	0	7.00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)		25	9, 125	41, 064. 00	0	14. 00
15. 00	CAH visits			7, 120	11,001.00	ő	15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE	20.00					24. 00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24. 10 25. 00
26. 00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01				o o	26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				o l	26. 25
27. 00	Total (sum of lines 14-26)	07.00	25			Ĭ	27. 00
28. 00	Observation Bed Days					o	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
00 -	outpatient days (see instructions)						
33.00	1						33.00
33. 01	LTCH site neutral days and discharges	20.00	,				33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0	1	0	34.00

Health Financial Systems SALEM THOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1345

| Peri od: | Worksheet S-3 | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared:

				1	0 03/31/2023	8/29/2023 9: 2	
		I/P Davs	/ O/P Visits	/ Trips	Full Time	Equi val ents	<u> </u>
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 053	2	1, 711			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	120	115				2.00
2. 00 3. 00	HMO and other (see instructions)	130	115 O				2.00 3.00
4. 00	HMO IPF Subprovider HMO IRF Subprovider	0	ol Ol				4.00
5. 00	1 · · · · · · · · · · · · · · · · · · ·	581	0	733			5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	301	ol	/33			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 634	2	2, 444			7.00
7.00	beds) (see instructions)	1,034	2	2, 444			7.00
8. 00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 634	2	2, 444	0.00	182. 51	14.00
15.00	CAH vi si ts	0	0	0			15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE			0			24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10 25. 00
25. 00 26. 00	CMHC	1, 923	o	15, 944	0. 00	16.06	
26. 00	RURAL HEALTH CLINIC	2, 265	o	5, 985	0.00	10.58	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	2, 203	0	5, 9 65	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)		o _l	0	0.00	209. 15	27.00
28. 00	Observation Bed Days		o	426		207. 13	28.00
29. 00	Ambulance Trips	0	Ÿ.	420			29.00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	o	o	0			32.00
32. 01	Total ancillary labor & delivery room	1	-	0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

| Peri od: | Worksheet S-3 | From 04/01/2022 | Part I | Date/Time | Prepared: | Date/Time | Prepared: | Part | Prepared: | Part Provider CCN: 14-1345

				To	03/31/2023	Date/Time Pre 8/29/2023 9: 2	
		Full Time		Di sch	arges	0/2//2023 7.2	O dill
		Equi val ents			. 5		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	277	1	445	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			33	39		2.00
3. 00	HMO IPF Subprovider]	0		3.00
4. 00	HMO IRF Subprovider			•	0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				, and the second		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	277	1	445	1
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - I PF			•			16. 00 17. 00
17. 00 18. 00	SUBPROVI DER - I RF SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY			•			19.00
20. 00	NURSING FACILITY			•			20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
31.00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32.00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			l ő			33. 01
	Temporary Expansion COVID-19 PHE Acute Care						34.00

City State ZIP Code 2.00 3.00 2.00 3.00 3.00 2.00 3.	Heal th	n Financial Systems	SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CMS-	2552-10
Component CON: 14-3413 To 03/31/20/3 Date/Time Preparation Pre	HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der 0	CCN: 14-1345		Worksheet S-8	3
1.00				Component	CCN: 14-3413			
Clinic Address and Identification						RHC I		
Clinic Address and Identification								1
1.00 Street		Clinic Address and Identification				l.	00	
City State ZIP Code Code County SALEM 1.00 2.00 3.00 City, State, ZIP Code County SALEM 1.00 2.00 3.00 City, State, ZIP Code County SALEM 1.00 2.00 3.00 City, State, ZIP Code County SALEM 1.00 2.00 City Community Real Format Community Real th Center (Section 330(d), PRS Act) Community Real that Services for the Homeless (Section 340(d), PRS Act) Community Real that Services for the Homeless (Section 340(d), PRS Act) Community Real that Services for the Homeless (Section 340(d), PRS Act) Community Real that Services for the Homeless (Section 340(d), PRS Act) Community Real that Services for the Homeless (Section 340(d), PRS Act) Community Real that Services for the Homeless (Section 340(d), PRS Act) Community Real that Services for Real	1. 00					1201 RICKER DR	I VE	1.00
2.00 City, State, ZIP Code, County SALEM IL 62881 2.00								
1.00		Tarrico de la companya della companya della companya de la companya de la companya della company			. 00			
No. HoSPITAL-BASED FORCS ONLY: Designation = Enter "R" for rural or "U" for urbs Grant Award Date	2. 00	City, State, ZIP Code, County		SALEM		I L	62881	2.00
No. HoSPITAL-BASED FORCS ONLY: Designation = Enter "R" for rural or "U" for urbs Grant Award Date							1 00	
Source of Federal Funds	3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban			3.00
Source of Federal Funds		·						
4.00 Community Health Center (Section 330(d), PHS Act) 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Migrant Health Center (Section 329(d), PHS Act) 5.00 Migrant Health Center (Section 329(d), PHS Act) 6.00 7.00 Appla achian Regional Commission 8.00 10.00 Look-Alikes 9.00 OTHER 1.00 2.00 10.00 2.00 10.00 2.00 10.00 2.00 10.00 2.00 10.00 2.00 10.00 2.00 10.00 2.00 10.00 2.00 10.00 2.00 10.00 2.00 10.00		Causas of Fadaval Funda				1. 00	2. 00	-
5.00 Migrant Health Center (Section 329(d), PHS Act) 6.00 Health Services for the Honeless (Section 340(d), PHS Act) 6.00 Appal achian Regional Commission 7.00 Appal achian Regional Commission 7.00 8.00 Look-Alikes 8.00 Look-Alikes 8.00 9.00 OTHER 1.00 2.00 10.00 Does this facility operate as other than a hospital-based RHC or FOHC? Enter "V" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating Nonday Tuesday Tuesday Tuesday Nonday Tuesday Tuesday Tuesday Nonday Tuesday T	4 00		: Act)		T			4 00
6.00 Heal th Services for the Honeless (Section 340(d), PHS Act) 6.00 7.00 Appal achian Regional Commission 7.00 8.00 1.00k-Alikes 7.00 1.00k 1.00								5.00
10.00 10.0							•	6.00
9.00 OTHER								7.00
1.00 2.00								
10.00 Does this facility operate as other than a hospital -based RRC or FORC? Enter "" for no in column 1. If yes, indicate nameber of other operations in column 2. (Enter in subscripts of line 11 the type of other operations in column 2. (Enter in subscripts of line 11 the type of other operations) and the operating Sunday	9.00	OTHER						9.00
10.00 Does this facility operate as other than a hospital -based RRC or FORC? Enter "" for no in column 1. If yes, indicate nameber of other operations in column 2. (Enter in subscripts of line 11 the type of other operations in column 2. (Enter in subscripts of line 11 the type of other operations) and the operating Sunday						1. 00	2. 00	
2 (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday	10.00	Does this facility operate as other than a h	nospi tal -based	RHC or FQHC? E	nter "Y" for			10.00
Nours. Sunday								
Sunday Monday Tuesday From to			of other operat	ion(s) and the	operating			
From to from to from		nours.)	Sur	nday	1	londay	Tuesday	
1.00 2.00 3.00 4.00 5.00								
11.00 CLINIC								
1.00 2.00 2.00 1.00 2.00 1.00 2.00 1.00								
12.00 Have you received an approval for an exception to the productivity standard? 13.00 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 report. List the names of all providers and numbers below. Provider name CCN 1.00 2.00	11. 00	CLINIC	09: 00	18: 30	09: 00	18: 30	09: 00	11.00
12.00 Have you received an approval for an exception to the productivity standard? 13.00 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 report. List the names of all providers and numbers below. Provider name CCN 1.00 2.00						1 00	2 00	
13.00	12. 00	Have you received an approval for an excepti	on to the prod	luctivity stand	lard?		2.00	12.00
number of providers included in this report. List the names of all providers and numbers below. Provider name CCN 1.00 2.00 14.00 RHC/FQHC name, CCN Y/N V XVIII XIX Total Visits 1.00 2.00 3.00 4.00 5.00 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in col umn 1. If yes, enter in col umns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in col umn 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County MARION Tuesday Wednesday Thursday to from from to from from to from to from from to from from to from from from from from from from fro						N	0	13.00
Numbers below. Provider name CCN 1.00 2.00								
Provider name CCN 1.00 2.00			List the name	s of all provi	ders and			
1.00 2.00		Trumber's berow.			Prov	ider name	CCN	
Y/N V XVIII XIX Total Visits								
1. 00 2. 00 3. 00 4. 00 5. 00 15. 00 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) County 4.00	14.00	RHC/FQHC name, CCN						14. 00
15.00 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) County								-
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) County 4.00	15.00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5. 00	15 00
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) County	13.00		1					15.00
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) County 4.00 2.00 City, State, ZIP Code, County MARION Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00								
XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions) County 4.00 2.00 City, State, ZIP Code, County MARION Tuesday to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)								
number of total visits for this provider.								
County 4.00 2.00 City, State, ZIP Code, County MARI ON 2.00								
County 4.00		· ·						
Z. 00 Ci ty, State, ZI P Code, County MARI ON 2. 00 Tuesday Wednesday Thursday to from to from to 6. 00 7. 00 8. 00 9. 00 10. 00								
Tuesday Wednesday Thursday to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)					00			
to from to from to 6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)	2. 00	City, State, ZIP Code, County	Tuesday		anday.	TI	e dov	2.00
6.00 7.00 8.00 9.00 10.00 Facility hours of operations (1)								
Facility hours of operations (1)								
11. 00 CLINIC 18: 30 09: 00 18: 30 09: 00 18: 30 11. 00		Facility hours of operations (1)	5. 00	7.00	3.00	<u> </u>	10.00	
	11. 00	CLINIC	18: 30	09: 00	18: 30	09: 00	18: 30	1 1. 00

Health Financial Systems	SALEM TOWNSH	II P HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Peri od:	Worksheet S-8	}
		Component		From 04/01/2022 To 03/31/2023		
				RHC I	Cost	
	Fri	day	Sat	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	09: 00	18: 30	09: 00	18: 30		11. 00

Heal th	n Financial Systems	SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 14-1345	Peri od: From 04/01/2022	Worksheet S-8	3
			Component	CCN: 14-8608	To 03/31/2023		
					RHC I I	Cost	
					4	22	1
	Clinic Address and Identification				I.	00	
1. 00	Street				1321 W WHITTAK	ER ST	1.00
			Ci	ty	State	ZIP Code	1
				00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County		SALEM			62881	2.00
						1. 00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		0	3.00
					nt Award	Date	
					1. 00	2. 00	
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	: Act)		T		I	4.00
5. 00	Migrant Health Center (Section 339(d), PHS A						5.00
6. 00	Health Services for the Homeless (Section 34						6.00
7. 00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10.00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for			10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type of	of other operat	ion(s) and the	operating			
	hours.)	Sur	nday	1 1	 Monday	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3.00	4. 00	5. 00	
	Facility hours of operations (1)					,	
11.00	CLINIC			08: 00	17: 00	08: 00	11.00
					1. 00	2. 00	
12. 00	Have you received an approval for an excepti	on to the prod	luctivity stand	lard?	N N	2.00	12.00
13.00					N	0	13.00
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report. numbers below.	List the name	s of all provi	ders and			
	Trumber's berow.			Prov	ider name	CCN	
					1. 00	2. 00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V 2.00	XVIII	XIX	Total Visits	
15. 00	Have you provided all or substantially all	1. 00	2. 00	3.00	4. 00	5. 00	15. 00
13.00	GME cost? Enter "Y" for yes or "N" for no in						13.00
	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)						
				inty			
				00			
2. 00	City, State, ZIP Code, County	Tuesday	MARI ON Woods	anday.	TI	anday.	2.00
		Tuesday to	from Wedn	esday to	from	sday to	
		6. 00	7. 00	8. 00	9.00	10.00	
	Facility hours of operations (1)	3.00	7.00	3.00	7.00		
11.00	CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11.00

Health Financial Systems	SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Peri od:	Worksheet S-8	}
		Component		From 04/01/2022 To 03/31/2023		
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

Heal th	Financial Systems SALEM TOWNSHIP H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 14-1345	Peri od:	Worksheet S-1			
				From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9:2	pared:		
					0/2//2020 /. 2	o dili		
					1. 00			
	Uncompensated and indigent care cost computation			->				
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by li	ine 202 colum	n 8)	0. 227341	1. 00		
2. 00	Net revenue from Medicaid				4, 670, 805	2. 00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen	ntal paymen [.]	ts from Medio	ai d?	Υ	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments 1	from Medicai	i d		0	5.00		
6. 00	Medi cai d charges				34, 555, 900			
7. 00 8. 00	Medicaid cost (line 1 times line 6)	(Line 7 min	auc cum of Li	noc 2 and E. if	7, 855, 973			
0.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(TITIE / IIII)	ius suii oi ii	nes 2 and 5, 11	3, 185, 168	6.00		
	Children's Health Insurance Program (CHIP) (see instructions f	for each lir	ne)					
9. 00	Net revenue from stand-alone CHIP		•		0	9. 00		
10.00	Stand-alone CHIP charges				0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)	(1: 11:		:6 +	0	11.00		
12. 00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(Tine II mi	inus iine 9;	ir < zero tnen	0	12. 00		
	Other state or local government indigent care program (see ins	structions 1	for each line	e)				
13.00	Net revenue from state or local indigent care program (Not ind				0	13.00		
14.00	Charges for patients covered under state or local indigent can	re program	(Not included	lin lines 6 or	0	14.00		
45.00	10)					45.00		
15. 00 16. 00	State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in		o program (Li	no 15 minus Lina	0	15. 00 16. 00		
10.00	13; if < zero then enter zero)	idi gerit. Car	e program (11	THE TO HILLIUS TITLE	. 0	10.00		
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)							
17. 00		fundi ng chai	rity care		0	17. 00		
18.00	Government grants, appropriations or transfers for support of				0			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local	al indigent	care program	ns (sum of lines	3, 185, 168	19. 00		
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1			
			patients	patients	+ col . 2)			
			1.00	2.00	3. 00			
	Uncompensated Care (see instructions for each line)							
20. 00	Charity care charges and uninsured discounts for the entire face instructions)	,	2, 270, 1	87 207, 226	2, 477, 413	20. 00		
21. 00	Cost of patients approved for charity care and uninsured disconstructions)	ounts (see	516, 1	207, 226	723, 333	21. 00		
22. 00	Payments received from patients for amounts previously written	n off as		0 0	0	22. 00		
23. 00	charity care Cost of charity care (line 21 minus line 22)		516, 1	207, 226	723, 333	23. 00		
24 00	Does the amount on line 20 column 2, include charges for patic	ant days hav	uand a Langth	of atou limit	1. 00 N	24.00		
24. 00	limposed on patients covered by Medicaid or other indigent care		yonu a rengti	I OI Stay IIIII t	IN	24. 00		
25. 00	If line 24 is yes, enter the charges for patient days beyond stay limit	. 5	t care progra	mm's length of	0	25.00		
26. 00	Total bad debt expense for the entire hospital complex (see in	nstructions`)		2, 002, 451	26. 00		
27. 00	Medicare reimbursable bad debts for the entire hospital comple				17, 972	27. 00		
27. 01	Medicare allowable bad debts for the entire hospital complex	(see instru	ctions)		27, 650			
28. 00	Non-Medicare bad debt expense (see instructions)	,		`	1, 974, 801	28.00		
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	xpense (see	ı nstructi ons	5)	458, 631	29.00		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			1, 181, 964 4, 367, 132			
51.00	1. Sta. a.m. Stimbar Sea and and imperior care care cost (Trine 17 pras)				1, 307, 132	31.00		

Health Financial Systems	SALEM TOWNSHIP	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der Co	CN: 14-1345 F	Peri od:	Worksheet A	
				From 04/01/2022 To 03/31/2023	Date/Time Pre	parod:
				10 03/31/2023	8/29/2023 9: 2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fi ed	<u> </u>
			+ col . 2)	i ons (See	Trial Balance	
			,	A-6)	(col. 3 +-	
				,	col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	<u> </u>					
1.00 O0100 CAP REL COSTS-BLDG & FLXT		1, 533, 103	1, 533, 103	521, 506	2, 054, 609	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		1, 208, 550	1, 208, 550	ol ol	1, 208, 550	2.00
3.00 00300 OTHER CAP REL COSTS		0			0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	247, 024	4, 114, 345	4, 361, 369	el ol	4, 361, 369	4.00
5. 01 00592 ADMINISTRATIVE & GENERAL	2, 025, 862	3, 531, 797	5, 557, 659		5, 036, 106	5. 01
6. 00 00600 MAINTENANCE & REPAIRS	0	0			0	6.00
7.00 00700 OPERATION OF PLANT	331, 922	786, 402	1, 118, 324	1 o	1, 118, 324	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	92, 850	37, 294	130, 144		130, 144	8. 00
9. 00 00900 HOUSEKEEPI NG	341, 250	83, 537	424, 787	7 0	424, 787	9. 00
10. 00 01000 DI ETARY	545, 597	478, 517	1, 024, 114	1 0	1, 024, 114	10.00
11. 00 01100 CAFETERI A	O	0	(ol ol	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	o	0	(ol ol	0	12.00
13.00 01300 NURSING ADMINISTRATION	15, 967	831	16, 798	3 ol	16, 798	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	137, 601	1, 312	138, 913		138, 913	14.00
15. 00 01500 PHARMACY	66, 942	1, 622, 274	1, 689, 216		1, 681, 796	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	378, 559	70, 168	448, 727		448, 727	16.00
17. 00 01700 SOCIAL SERVICE	0	0	(1	0	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	o	468, 433	468, 433	0	468, 433	19.00
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			`.		
30. 00 03000 ADULTS & PEDIATRICS	2, 464, 620	1, 213, 704	3, 678, 324	-32, 136	3, 646, 188	30.00
ANCILLARY SERVICE COST CENTERS	, , , , , , , ,	,				
50. 00 05000 OPERATING ROOM	1, 046, 439	1, 499, 663	2, 546, 102	-278, 872	2, 267, 230	50.00
53. 00 05300 ANESTHESI OLOGY	0	4, 050	4, 050		4, 050	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	765, 132	499, 655	1, 264, 787			54.00
57. 00 05700 CT SCAN	98, 719	155, 838	254, 557		239, 776	57.00
58. 00 05800 MRI	77, 336	-38, 214	39, 122		32, 078	58.00
60. 00 06000 LABORATORY	831, 381	1, 841, 693	2, 673, 074		2, 673, 074	60.00
65. 00 06500 RESPIRATORY THERAPY	446, 239	126, 336	572, 575		572, 227	65.00
66. 00 06600 PHYSI CAL THERAPY	0	647, 205	647, 205		658, 193	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	O	108, 055	108, 055		95, 099	67.00
68. 00 06800 SPEECH PATHOLOGY	O	0	(1, 825	68.00
69. 00 06900 ELECTROCARDI OLOGY	48, 150	44, 968	93, 118		93, 118	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	6, 324	6, 324		494, 922	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	449, 978	449, 978		449, 978	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	1, 149	1, 149	el ol	1, 149	73.00
76. 00 03550 BEHAVI ORAL HEALTH	199, 274	139, 757	339, 03 ²	ıl ol	339, 031	76.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	1, 393, 256	590, 060	1, 983, 316	1, 523	1, 984, 839	88.00
88.01 08801 RURAL HEALTH CLINIC II	1, 185, 579	137, 145	1, 322, 724	5, 897	1, 328, 621	88. 01
90. 00 09000 CLI NI C	239, 792	57, 427	297, 219	-8, 111	289, 108	90.00
90.01 09001 SALEM MEDICAL CLINIC	0	0	(ol ol	0	90. 01
91. 00 09100 EMERGENCY	1, 514, 325	2, 423, 051	3, 937, 376	-68, 989	3, 868, 387	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	14, 493, 816	23, 844, 407	38, 338, 223	3 4	38, 338, 227	118.00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES	68, 686	7, 202	75, 888	3 ol	75, 888	192. 00
192.01 19201 TEMPORALLY IDLE SPACE		0		ol ol	0	192. 01
192.02 19202 STH FAM HLTH CRT	-15, 673	720	-14, 953	-4	-14, 957	
192. 03 19203 RI SE OUTREACH LAB		0	(ol ol	0	192. 03
194.00 07950 LITIGATION COSTS		0		o	0	194. 00
194.01 07951 MT VERNON SURGICAL CLINIC	27, 294	7, 243	34, 537	7 0	34, 537	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	14, 574, 123	23, 859, 572	38, 433, 695	0	38, 433, 695	200.00
	·			·		

 Health Financial
 Systems
 SALEM TOWN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1345

				8/29/2	2023 9:20 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	-492, 258	1, 562, 351		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	1, 208, 550		2.00
3.00	00300 OTHER CAP REL COSTS	0	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-59, 888	4, 301, 481		4.00
5. 01	00592 ADMINISTRATIVE & GENERAL	-127, 504	4, 908, 602		5. 01
6.00	00600 MAINTENANCE & REPAIRS	0	О		6. 00
7.00	00700 OPERATION OF PLANT	-1, 111	1, 117, 213		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	130, 144		8. 00
9.00	00900 HOUSEKEEPI NG	0	424, 787		9. 00
10.00	01000 DI ETARY	-217, 428			10.00
11.00	01100 CAFETERI A	0	o		11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	o		12.00
13.00		0	16, 798		13.00
14.00		0	138, 913		14.00
15. 00	01500 PHARMACY	0	1, 681, 796		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	448, 727		16.00
17. 00	01700 SOCI AL SERVI CE	0	0		17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	-468, 433	· ·		19.00
. ,	INPATIENT ROUTINE SERVICE COST CENTERS	1007 100	5		17.00
30. 00		-774, 000	2, 872, 188		30.00
00.00	ANCILLARY SERVICE COST CENTERS	77.17.000	2,0,2,100		
50. 00		-373, 590	1, 893, 640		50.00
53. 00		-4, 050			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-25	1, 186, 639		54.00
57. 00		0	239, 776		57.00
58. 00		0	32, 078		58.00
60. 00	06000 LABORATORY	0	2, 673, 074		60.00
65. 00	06500 RESPI RATORY THERAPY	-36, 880			65.00
66. 00	06600 PHYSI CAL THERAPY	-30, 000	658, 193		66.00
67. 00		0			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1, 825		68.00
69. 00	06900 ELECTROCARDI OLOGY	-38, 991	54, 127		69.00
71. 00		-30, 771	494, 922		71.00
72. 00		0	449, 978		72.00
73. 00		-3, 877	-2, 728		73. 00
	03550 BEHAVI ORAL HEALTH	-1, 599	337, 432		76.00
70.00	OUTPATIENT SERVICE COST CENTERS	-1, 377	337, 432		70.00
88. 00		0	1, 984, 839		88. 00
88. 01		0	· · · · · · · · · · · · · · · · · · ·		88. 01
90.00		-7, 035			90.00
90. 00	09001 SALEM MEDICAL CLINIC	-7,033	202, 073		90.00
91.00		-1, 073, 928	- 1		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	-1,073,720	2, 794, 459		92.00
92.00	SPECIAL PURPOSE COST CENTERS				92.00
118.00		-3, 680, 597	34, 657, 630		118. 00
110.00	NONREI MBURSABLE COST CENTERS	-3,000,397	34, 657, 630		110.00
100 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190. 00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	0	75, 888		190.00
	1 19200 PHYSICIANS PRIVATE OFFICES	0	73,000		192.00
	2 19202 STH FAM HLTH CRT	0	14 057		192.01
	3 19203 RISE OUTREACH LAB	0	-14, 957 0		192. 02
	007950 LITIGATION COSTS	0	0		192.03
		0	· ·		194.00
200.00	107951 MT VERNON SURGICAL CLINIC TOTAL (SUM OF LINES 118 through 199)	-3, 680, 597	,		200. 00
200.00	TIVIAL (SUM OF LINES 110 LITTOUGH 199)	-3,000,397	34, 133, 070		₁ 200.00

Health Financial Systems

SALEM TOWNSHIP HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 14-1345

Period: From 04/01/2022
To 03/31/2023 Date/Time Prepared:

					To 03/31/	/2023 Date/Time Prepared: 8/29/2023 9:20 am
		Increases			<u> </u>	
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
	A - RECLASS THERAPY COSTS					
1.00	PHYSI CAL THERAPY	66. 00	0	10, 990		1.00
2.00	SPEECH PATHOLOGY	68. 00	0	1, 825		2.00
	TOTALS			12, 815		
	B - TO RECLASSIFY SUPPLY COST	·	<u> </u>	·		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	488, 598		1.00
	PATI ENT					
3.00		0. 00	O	0		3.00
4.00		0. 00	O	0		4.00
5.00		0.00	O	0		5. 00
6.00		0.00	o	0		6.00
7.00		0.00	0	0		7.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	488, 598		
	C - RECLASS DRUG COSTS TO RHO					
1.00	RURAL HEALTH CLINIC	88. 00	0	1, 523		1.00
2.00	RURAL HEALTH CLINIC I	8801	0	<u>5, 8</u> 97		2.00
	TOTALS		0	7, 420		
	F - TO RECLASS INTEREST EXPEN					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	492, 258		1.00
	0		0	492, 258		
	G - TO RECLASS OTHER CAPITAL	COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	29, 248		1.00
2.00		0.00	0	0		2. 00
	0		0	29, 248		
500.00	Grand Total: Increases		O	1, 030, 339		500.00

Health Financial Systems RECLASSIFICATIONS SALEM TOWNSHIP HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-1345

Decreases							10 03/31/2023	8/29/2023 9: 20 am
Color			Decreases					
A - RECLASS THERAPY COSTS		Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
1. 00 OCCUPATI ONAL THERAPY 07. 00 0 12,815 0 0 2. 00 0 0 0 0 0 0 0 0 0		6. 00	7. 00	8. 00	9. 00	10.00		
2.00		A - RECLASS THERAPY COSTS						
TOTALS		OCCUPATI ONAL THERAPY	67. 00	0	12, 815	C)	1.00
B - TO RECLASSI FY SUPPLY COST	2.00		0.00	0	0			2.00
1. 00 ADMINISTRATIVE & GENERAL 5. 01 0 47 0 3. 00 ADMINISTRATICS 30. 00 0 32, 136 0 3. 00 ADMINISTRATICS 30. 00 0 278, 872 0 4. 00 OPERATING ROOM 50. 00 0 278, 872 0 4. 00 OPERATING ROOM 50. 00 0 78, 123 0 5. 00 6. 00 CT SCAN 57. 00 0 14, 781 0 6. 00 7. 00 MRI 58. 00 0 7, 044 0 7. 00 9. 00 RSSPIRATORY THERAPY 65. 00 0 348 0 9. 00 10. 00 Physical Therapy 66. 00 0 2 0 0 10. 00 11. 00 0 0 0 0 0 0 0 0 0				0	12, 815			
3. 00 ADULTS & PEDIATRICS 30. 00 0 32, 136 0 0 4. 00 0 0 0 278, 872 0 0 4. 00 0 0 0 0 0 0 0 0 0								
4. 00 OPERATI NG ROOM 50. 00 278, 872 0 4. 00 5. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 78, 123 0 5. 00 6. 00 CT SCAN 57. 00 0 14, 781 0 6. 00 7. 00 MRI 58. 00 0 7, 044 0 7. 00 9. 00 RESPIRATORY THERAPY 65. 00 0 348 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 2 0 10. 00 11. 00 OCCUPATI ONAL THERAPY 67. 00 0 141 0 11. 00 15. 00 CLI NI C 90. 00 0 8, 111 0 15. 00 16. 00 EMERGENCY 91. 00 0 88, 111 0 15. 00 17. 00 STH FAM HLTH CRT 192. 02 0 4 0 17. 00 0 CC RECLASS DRUG COSTS TO RHC 1. 00 PHARMACY 15. 00 0 7, 420 0 17. 00 10. 00 TOTALS 7. 00 0 7, 420 0 2. 00 10. 00 488, 598 10 10. 00 TOTALS 15. 01 0 492, 258 11 0 0 10. 00 10. 00 ADMINISTRATI VE & GENERAL 5. 01 0 492, 258 11 0 0 0 29, 248 14 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
5. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 78, 123 0 5. 00 6. 00 CT SCAN 57. 00 0 14, 781 0 6. 00 7. 00 MRI 58. 00 0 7, 044 0 7. 00 9. 00 RESPI RATORY THERAPY 65. 00 0 348 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 2 0 10. 00 11. 00 OCCUPATI ONAL THERAPY 67. 00 0 141 0 11. 00 15. 00 CLI NI C 90. 00 0 8. 111 0 15. 00 16. 00 EMERGENCY 91. 00 0 68, 989 0 16. 00 17. 00 STH FAM HLTH CRT 192. 02 0 48, 598 0 17. 00 0 C - RECLASS DRUG COSTS TO RHC 0 0 7, 420 0 1. 00 2. 00 TOTALS 0 0 7, 420 0 2. 00 TOTALS 0 0 7, 420 0 2. 00 F - TO RECLASS INTEREST EXPENSE 1 1 0 492, 258 11 0 0 0 492, 258 11 1 0 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td>				0				
6. 00 CT SCAN 57. 00 0 14,781 0 6. 00 7. 00 MRI 58. 00 0 7,044 0 7. 00 9. 00 RESPIRATORY THERAPY 65. 00 0 348 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 2 0 10. 00 11. 00 OCCUPATI ONAL THERAPY 67. 00 0 11. 00 15. 00 CLI NI C 90. 00 0 8, 111 0 15. 00 16. 00 EMERGENCY 91. 00 0 68, 989 0 16. 00 17. 00 STH FAM HLTH CRT 192. 02 0 4 0 17. 00 17. 00 STH FAM HAMACY 15. 00 0 7, 420 0 17. 00 10 C - RECLASS DRUG COSTS TO RHC 1. 00 PHARMACY 15. 00 0 7, 420 0 2. 00 10 TOTALS 0 7, 420 0 2. 00 10 TOTALS 0 7, 420 0 1. 00 10 TOTALS 0 7, 420 0 1. 00 10 TOTALS 15. 01 0 492, 258 11 0 1. 00 10 ADMINISTRATIVE & GENERAL 5. 01 0 492, 258 11 0 0 0 0 0 0 140 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0)	
7. 00 9. 00 RESPIRATORY THERAPY 65. 00 0 348 0 9. 00 10. 00 PHYSI CAL THERAPY 66. 00 0 2 0 11. 00 OCUPATI ONAL THERAPY 66. 00 0 1411 0 15. 00 CLI NI C 90. 00 0 8, 111 0 15. 00 16. 00 EMERGENCY 91. 00 0 488, 598 0 17. 00 2. 00 0 488, 598 0 17. 00 2. 00 0 488, 598 0 17. 00 2. 00 0 488, 598 11 0 10. 00 2. 00 0 488, 598 11 0 10. 00 2. 00 0 488, 598 11 0 10. 00 0 492, 258 11 0 492, 258 0 40 0 492, 258 11 0 1. 00 0 492, 258 11 0 1. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0)	
9. 00 RESPIRATORY THERAPY 65. 00 0 10. 00 PHYSI CAL THERAPY 66. 00 0 11. 00 OCCUPATI ONAL THERAPY 67. 00 0 11. 00 OCCUPATI ONAL THERAPY 67. 00 0 0 18. 111 0 0 18. 00 19. 00 11.				0)	
10.00 PHYSI CAL THERAPY 66.00 0 2 0 10.00 11.00 OCCUPATI ONAL THERAPY 67.00 0 141 0 11.00 15.00 CLI NI C 90.00 0 8, 111 0 15.00 16.00 EMERGENCY 91.00 0 68, 989 0 16.00 17.00 STH FAM HLTH CRT 192.02 0 4 0 17.00 C - RECLASS DRUG COSTS TO RHC 1.00 PHARMACY 15.00 0 7, 420 0 2.00 TOTALS 0 7, 420 0 2.00 TOTALS 0 7, 420 0 2.00 TOTALS 1 0 7, 420 0 1.00 F - TO RECLASS INTEREST EXPENSE 1.00 ADMI NI STRATI VE & GENERAL 5.01 0 492, 258 11 1 1.00 ADMI NI STRATI VE & GENERAL 5.01 0 29, 248 14 1.00 O 0 29, 248 14 1.00				0)	
11. 00 OCCUPATI ONAL THERAPY 67. 00 0 141 0 15. 00 15. 00 CLI NI C 90. 00 0 8, 111 0 15. 00 16. 00 EMERGENCY 91. 00 0 68, 989 0 16. 00 17. 00 STH FAM HLTH CRT 192. 02 0 4 0 17. 00 0 0 488, 598 0 17. 00 2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	348		2	
15. 00 CLINI C 90. 00 0 8, 111 0 15. 00 16. 00 EMERGENCY 91. 00 0 68, 989 0 17. 00 STH FAM HLTH CRT 192. 02 0 4 0 0 0				0	2			
16. 00 EMERGENCY 91. 00 0 68, 989 0 16. 00 17. 00 STH FAM HLTH CRT 192. 02 0 4 0 17. 00 0 0 488, 598 0 17. 00 1. 00 488, 598 0 17. 00 2. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
17. 00 STH FAM HLTH CRT 192. 02 0 4 0 17. 00 C - RECLASS DRUG COSTS TO RHC 1. 00 PHARMACY 15. 00 0 7, 420 0 1. 00 TOTALS 0 0 7, 420 F - TO RECLASS INTEREST EXPENSE 1. 00 ADMI NI STRATI VE & GENERAL 5. 01 0 492, 258 11 0 0 G - TO RECLASS OTHER CAPI TAL COSTS 1. 00 ADMI NI STRATI VE & GENERAL 5. 01 0 29, 248 14 1. 00 C - TO RECLASS OTHER CAPI TAL COSTS 1. 00 ADMI NI STRATI VE & GENERAL 5. 01 0 29, 248 14 1. 00 C - TO RECLASS OTHER CAPI TAL COSTS				0				
C - RECLASS DRUG COSTS TO RHC				0	00, 909			
C - RECLASS DRUG COSTS TO RHC 1. 00 PHARMACY	17.00	O FAM HEIR CKI		+	4	 	<u>/</u>	17.00
1. 00 PHARMACY 15. 00 0 7, 420 0 2. 00 TOTALS 0 0 7, 420 F - TO RECLASS INTEREST EXPENSE 1. 00 ADMI NI STRATI VE & GENERAL 5. 01 0 492, 258 11 0 0 492, 258 11 0 0 492, 258 11 0 0 492, 258 11 0 0 492, 258 11 0 0 0 492, 258 11 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		C - PECLASS DRUG COSTS TO PHO		<u> </u>	400, 570			
2. 00 TOTALS F - TO RECLASS INTEREST EXPENSE 1. 00 ADMI NI STRATI VE & GENERAL 0 492, 258 G - TO RECLASS OTHER CAPITAL COSTS 1. 00 ADMI NI STRATI VE & GENERAL 0 0 492, 258 1. 00 ADMI NI STRATI VE & GENERAL 0 0 492, 258 1. 00 ADMI NI STRATI VE & GENERAL 0 0 29, 248 1. 00 0 29, 248 1. 00 0 29, 248	1 00			٥	7 420	1		1 00
TOTALS F - TO RECLASS INTEREST EXPENSE 1. 00 ADMI NI STRATI VE & GENERAL 0		1 TIPARWING I		0	7, 420			
F - TO RECLASS INTEREST EXPENSE 1. 00	2.00	TOTALS — — — —		— — — j	$ \frac{7}{7} \frac{1}{420}$	 	1	2.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 01 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 492, 258 11 0 1. 00 0 10 0 10 0 10 0 10 0 10 0			NSF	<u> </u>	7, 120	1		
0	1.00			0	492, 258	11		1.00
G - TO RECLASS OTHER CAPITAL COSTS 1. 00 ADMINISTRATIVE & GENERAL 5. 01 0 29, 248 14 1. 00 2. 00 0 29, 248 2. 00		0		— — 				
2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		G - TO RECLASS OTHER CAPITAL	COSTS		,	•	'	
0 29, 248	1.00	ADMINISTRATIVE & GENERAL	5. 01	0	29, 248	14	ļ	1.00
	2.00		0.00	0	0	14	ļ	2.00
500.00 Grand Total: Decreases 0 1,030,339 500.00		0 — — — — —			29, 248			
	500.00	Grand Total: Decreases		0	1, 030, 339			500.00

				To	03/31/2023	Date/Time Pre 8/29/2023 9: 2	
				Acqui si ti ons		0/27/2023 7.2	O alli
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	203, 353	0	0	0	0	1.00
2.00	Land Improvements	1, 191, 840	0	0	0	0	2.00
3.00	Buildings and Fixtures	35, 340, 942	188, 771	0	188, 771	134, 000	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2, 831, 440	0	0	0	2, 245	5.00
6.00	Movable Equipment	10, 606, 970	4, 875, 885	0	4, 875, 885	505, 235	6.00
7.00	HIT designated Assets	1, 079, 269	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	51, 253, 814	5, 064, 656	0	5, 064, 656	641, 480	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	51, 253, 814	5, 064, 656	0	5, 064, 656	641, 480	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DART I ANALYSIS OF SUANISES IN SARITAL ASSE	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	203, 353	0				1.00
2.00	Land Improvements	1, 191, 840	0				2.00
3.00	Buildings and Fixtures	35, 395, 713	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fi xed Equi pment	2, 829, 195	0				5.00
6.00	Movable Equipment	14, 977, 620	0				6.00
7.00	HIT designated Assets	1, 079, 269	0				7.00
8.00	Subtotal (sum of lines 1-7)	55, 676, 990	0				8.00
9.00	Reconciling Items	0 55 (7/ 000	0				9.00
10. 00	Total (line 8 minus line 9)	55, 676, 990	0				10.00

Heal th	Financial Systems	SALEM TOWNSHI	P HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 04/01/2022 To 03/31/2023		pared:
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see instructions)	
					instructions)	The true true	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 533, 103	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 170, 715	0	37, 83	0 0	0	2.00
3.00	Total (sum of lines 1-2)	2, 703, 818	0	37, 83	55 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
	·	Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
<u> </u>	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 533, 103		·	·	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1, 208, 550				2.00
3.00	Total (sum of lines 1-2)	0	2, 741, 653				3.00

Heal th	Financial Systems	SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 04/01/2022 To 03/31/2023		pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1.00	0.00	col . 2)		5.00	
	DART III DECONOLILIATION OF CARLTAL COCTO C	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C	39, 416, 748		20 417 74	0 770252	0	1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	16, 056, 889				Ŭ	1. 00 2. 00
3. 00	Total (sum of lines 1-2)	55, 473, 637					3.00
3.00	Total (Suil of Titles 1-2)		TION OF OTHER (F CAPI TAL	3.00
ALLOCATION OF STREET SUMMERS OF CALLIAL							
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	,				
1. 00	CAP REL COSTS-BLDG & FLXT	0	0		0 1, 533, 103		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 1, 170, 715		2.00
3.00	Total (sum of lines 1-2)	0	0		0 2, 703, 818	0	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions) Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
			,		instructions)	, ,	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0			0 29, 248		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	37, 835			0	1, 208, 550	2. 00
3.00	Total (sum of lines 1-2)	37, 835	0		0 29, 248	2, 770, 901	3. 00

ADJUST	WENTS TO EXPENSES			Provider Con. 14-1345	From 04/01/2022	WOLKSHEET A-0	
					To 03/31/2023	Date/Time Pre 8/29/2023 9:2	
			Т	Expense Classification of D/From Which the Amount is			
					J		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1 00	Investment income CAD DEL	1. 00 B	2. 00	3.00 AP REL COSTS-BLDG & FIXT	4.00	5. 00	1 00
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-492, 25807	AP REL CUSIS-BLDG & FIXI	1. 00	11	1.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		O C	AP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	Investment income - other	В	-35, 140 AI	OMINISTRATIVE & GENERAL	5. 01	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		o		0. 00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of	-	0		0.00	0	5.00
	expenses (chapter 8)		\mathbb{I}			0	
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6.00
7. 00	Tel ephone servi ces (pay	А	-1, 103 AI	OMINISTRATIVE & GENERAL	5. 01	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)	А	-10, 124 AI	OMINISTRATIVE & GENERAL	5. 01	0	8. 00
9. 00	Parking Lot (chapter 21)		О		0. 00	0	
10. 00	Provi der-based physician adjustment	A-8-2	-2, 302, 813			0	10.00
11. 00	Sale of scrap, waste, etc.		О		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	o			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service	-			0.00	0	13.00
14.00	Cafeteria-employees and guests	В	-172, 356 DI	ETARY	10. 00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		О		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		О		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		o		0. 00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		О		0. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22.00
22 00	repay Medicare overpayments	A-8-3	OD	ESPI RATORY THERAPY	65. 00		23.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	URI	ESPIRATURY THERAPY	65.00		23.00
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	OIPI	HYSI CAL THERAPY	66. 00		24.00
21.00	therapy costs in excess of	7. 0 0		THOUGHE THEIRWIT	00.00		21.00
25. 00	limitation (chapter 14) Utilization review –		0 *:	** Cost Center Deleted **	* 114.00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		o c	AP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		OlCA	AP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP	^				0	
28. 00 29. 00	'	А	-468, 433 NO	ONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	000	CCUPATIONAL THERAPY	67. 00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		OAI	DULTS & PEDIATRICS	30. 00		30. 99
	1		ı I		ı l		

Heal th	Health Financial Systems			IP HOSPITAL	In Lieu of Form CMS-2552-10		
	MENTS TO EXPENSES				eri od:	Worksheet A-8	
					rom 04/01/2022	Data (Time Data	
				T	o 03/31/2023	Date/Time Pre 8/29/2023 9:2	parea: O am
				Expense Classification on	Worksheet A	0/2//2023 7.2	O dill
				To/From Which the Amount is			
					,		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
31. 00	Adjustment for speech	1.00 A-8-3		SPEECH PATHOLOGY	4.00	5.00	31.00
31.00	pathology costs in excess of	A-0-3	0	SPEECH PATHOLOGY	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	9	32.00
32.00	Depreciation and Interest				0.00	,	32.00
33.00	ANESTHESI A EXPENSES	Α	-4, 050	ANESTHESI OLOGY	53. 00	0	33.00
34. 00	DI ETARY REVENUE	В		DI ETARY	10. 00	0	34.00
35.00	BUS OFFICE COSTS ASSOC W/ PHYS	Α	-40, 743	ADMINISTRATIVE & GENERAL	5. 01	0	35.00
37.00	UNALLOWABLE TRANSPORTATION	A	-1, 599	BEHAVI ORAL HEALTH	76. 00	0	37.00
	COSTS						
39.00	LOBBYING PORTION OF DUES	Α	-13, 688	ADMINISTRATIVE & GENERAL	5. 01	0	39. 00
40.00	MARKETI NG	A	-33, 398	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	40.00
41.00	PHARMACY 340B REVENUE	В		DRUGS CHARGED TO PATIENTS	73. 00	0	41.00
42.00	SURGERY MISC REVE	В	· ·	OPERATING ROOM	50.00	0	42.00
43.00	PHARMACY MISC REV	В	-306	DRUGS CHARGED TO PATIENTS	73. 00	0	43.00
44. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	44. 00
	(3)	_				_	
45.00	RADI OLOGY MI SC REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	10.00
46.00	FACILITIES MISC REVENUE	В	· ·	OPERATION OF PLANT	7. 00	0	46.00
47.00	OTHER MISC REV	В		ADMINISTRATIVE & GENERAL	5. 01	0	47.00
48. 00	PROVI DER BENEFITS	A	-26, 490	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	48.00

-3, 680, 597

-26, 696 ADMI NI STRATI VE & GENERAL

5. 01

49.00

50.00

TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,

49. 00 INT INCOME ON PAT ACCT

50.00

column 6, line 200.) (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.

Provider CCN: 14-1345

Peri od: Worksheet A-8-2 From 04/01/2022 To 03/31/2023 Date/Time Prepared:

						10 03/31/202	8/29/2023 9: 2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	· ·		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	774, 000	774, 000	0	C	0	1.00
2.00	50.00	OPERATING ROOM	371, 979			l	0	2.00
3.00	50.00	OPERATING ROOM	45, 000	0	45, 000	l	0	3.00
4.00	60.00	LABORATORY	112, 872	0	112, 872	l	0	4.00
5.00	65. 00	RESPIRATORY THERAPY	36, 880	36, 880	0	1	ol o	5. 00
6.00	69.00	ELECTROCARDI OLOGY	38, 991	38, 991	0	l	ol o	6. 00
7. 00		BEHAVI ORAL HEALTH	36,000		36, 000		ol o	7. 00
8. 00		EMERGENCY	2, 146, 138	1			ol o	8. 00
9. 00		CLI NI C	7, 035			1		9. 00
10.00	0.00		0	0		1		10.00
200.00	0.00		3, 568, 895	2, 302, 813	1, 266, 082		l ő	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physi ci an Cost	200.00
		I denti fi er		Unadjusted RCE		Component	of Mal practice	
		T don't T T o	2	Li mi t	Conti nui ng	Share of col.	Insurance	
					Education	12	11104141100	
	1, 00	2.00	8. 00	9, 00	12. 00	13. 00	14.00	
1. 00	30, 00	ADULTS & PEDIATRICS	0	0				1.00
2.00		OPERATING ROOM	0	0	0	1	ol o	2.00
3.00	50.00	OPERATING ROOM	0	0	0	1	ol o	3.00
4.00		LABORATORY	0	0	0		ol o	4.00
5. 00		RESPIRATORY THERAPY	0	0	0			5.00
6. 00		ELECTROCARDI OLOGY	0	0	0			6.00
7. 00		BEHAVI ORAL HEALTH	0	0	0	1	ol o	7. 00
8. 00		EMERGENCY	0	0	0	1	ol o	8.00
9. 00		CLINIC	0	l o	0	7	ol o	9. 00
10.00	0.00	MI.	0	0	0	7		
200.00	0.00		0	0	_			
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		I denti fi er	Component	Limit	Di sal I owance	/ ag do tillorre		
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00	1	
1. 00	30.00	ADULTS & PEDIATRICS	0	0	0	774, 000		1.00
2.00	50.00	OPERATING ROOM	0	0	0	371, 979		2.00
3. 00		OPERATING ROOM	0	0	0			3.00
4.00	60, 00	LABORATORY	0	0	0			4.00
5. 00		RESPIRATORY THERAPY	0	0	0	36, 880		5. 00
6. 00		ELECTROCARDI OLOGY	0	0	0	38, 991		6.00
7. 00		BEHAVI ORAL HEALTH	0	Ö	0	00, ,,,		7. 00
8. 00		EMERGENCY	1 0	0		1, 073, 928		8.00
9. 00		CLINIC	0	1	_	7, 035		9. 00
10. 00	0.00		0	0	_	7,000	1	10.00
200.00	0.00		0	1	_	1	1	200.00
200.00	I	I	1	1	1	2, 302, 013	1	200.00

	Financial Systems	SALEM TOWNSHIP				u of Form CMS-2	
	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CC	N: 14-1345	Peri od: From 04/01/2022 To 03/31/2023		pared:
					Physical Therapy	Cost	
						1. 00	
	PART I - GENERAL INFORMATION						
1.00 2.00 3.00 1.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	sor or therapist assistant was c	was on provi			52 780 260 0	1. 0 2. 0 3. 0 4. 0
00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the		0	5. C 6. C			
. 00	instructions) Standard travel expense rate					6. 22	7.0
3. 00	Optional travel expense rate per mile	C	The result of the latest terminal termi	A! . ! !	٨٠	0.00	8.0
		Supervi sors 1.00	Therapi sts 2.00	Assi stants 3.00	4. 00	Trai nees 5. 00	
9. 00	Total hours worked	0.00	4, 129. 00	5, 658.	0. 00	0. 00	9. 0
1. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00 47.42	94. 84 47. 42	71. 35.		0. 00	10.0 11.0
	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12. 0 12. 0
	Number of miles driven (provider site)		0		0		13.0
3. 01	Number of miles driven (offsite)	o	o		0		13. C
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
4. 00 5. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0 391, 594	
6. 00	Assistants (column 3, line 9 times column 3,					402, 454	16.0
7. 00 8. 00	Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line	•	ratory therapy	or lines 14	1-16 for all	794, 048 0	17. 0 18. 0
	Trainees (column 5, line 9 times column 5, l	i ne 10)				0	19.0
0.00		or respiratory t	therapy or lin	es 17 and 18	3 for all others)	794, 048	20.0
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	amount from line 20. Otherwise complete line	es 21-23.					
21. 00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,			m of columns	s 1 and 2, line 9	0.00	21.0
22. 00	Weighted allowance excluding aides and train					0	22.0
23. 00	Total salary equivalency (see instructions)	NANCE AND TRAVEL	EXPENSE COMP	ITATION D	DOVIDED CLTE	794, 048	23.0
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	WANCE AND TRAVEL	EXPENSE COMP	UTATION - Pr	KOVIDER SITE		
	Therapists (line 3 times column 2, line 11)					12, 329	
	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2/	land 25 for a	ll others)		0 12, 329	25. 0 26. 0
7. 00				,	3 and 4 for all	1, 617	27.0
8. 00	others) Total standard travel allowance and standard	travel expense	at the provid	er site (sur	n of lines 26 and	13, 946	28. 0
	27) Optional Travel Allowance and Optional Travel	I Expense					
	Therapists (column 2, line 10 times the sum	of columns 1 and	d 2, line 12)			0	29.0
	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or		and 20 for a	II othors)		0	30. C
	Optional travel expense (line 8 times column				oy or sum of	0	32.0
	columns 1-3, line 13 for all others)		·	,			
	Standard travel allowance and standard trave Optional travel allowance and standard trave			d 31)		13, 946 0	33. C
	Optional travel allowance and optional trave					0	35.0
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				RVICES OUTSIDE PR	ROVI DER SITE	
6. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36. 0
	LINELONA SIS LITUE STITUES COLUMN Z. TITLE III.					ı Ul	, 50. (

ealth Financial Systems	SALEM TOWNSHIP		ON 44 4045		u of Form CMS-2	
EASONABLE COST DETERMINATION FOR THERAPY SERVICES UTSIDE SUPPLIERS	FURNI SHED BY	Provi der Co	CN: 14-1345	Peri od: From 04/01/2022 To 03/31/2023	Worksheet A-8 Parts I-VI Date/Time Pre 8/29/2023 9:2	pared:
				Physical Therapy		
					1. 00	
6.00 Optional travel allowance and optional trave	el expense (sum o	of lines 42 ar	nd 43 - see i	nstructions)		46. 00
	Therapi sts	Assi stants	Ai des	Trai nees	Total	
PART V - OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
7.00 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)	0.00	0. 00	0. (0.00	0.00	47.00
8.00 Overtime rate (see instructions)	0.00	0.00	0. (0.00		48. 00
9.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00				49. 00
0.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0. (0.00	0.00	50.00
1.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0. (0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE	94.84	71. 13	0. (0.00		 52. 00
2.00 Adjusted hourly salary equivalency amount (see instructions)3.00 Overtime cost limitation (line 51 times line		71. 13	0.1	0 0		53.00
4.00 Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
6.00 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.)	0	0		0 0	0	56. 00
					1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION	AND EXCESS COST	ADJUSTMENT				
7.00 Salary equivalency amount (from line 23) 8.00 Travel allowance and expense - provider site 9.00 Travel allowance and expense - Offsite servi 0.00 Overtime allowance (from column 5, line 56) 1.00 Equipment cost (see instructions) 2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (from 5.00 Excess over limitation (line 64 minus line 64 LINE 33 CALCULATION	794, 048 13, 946 0 0 0 0 807, 994 397, 062	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00				
00.00 Line 26 = line 24 for respiratory therapy of 00.01 Line 27 = line 7 times line 3 for respirator 00.02 Line 33 = line 28 = sum of lines 26 and 27	12, 329 1, 617 13, 946	100.01				
O1. 00 Line 27 = line 7 times line 3 for respirator O1. 01 Line 31 = line 29 for respiratory therapy or O1. 02 Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
02.00 Line 31 = line 29 for respiratory therapy or 02.01 Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
13 for all others						102. 02

OUTSLE	ABLE COST DETERMINATION FOR THERAPY SERVICES	SALEM TOWNSHIP FURNISHED BY	Provi der CCI	N: 14-1345	Peri od:	Worksheet A-8	
	E SUPPLIERS				From 04/01/2022 To 03/31/2023		
					Occupati onal Therapy	Cost	o am
					o. ap y	1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aide	s) (see instruct	i ons)			23	1.0
2. 00 3. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi	sor or theranist	was on provi	dar sita (sa	a instructions)	345 128	2. 0 3. 0
1. 00	Number of unduplicated days in which therapy					0	4.0
- 00	nor therapist was on provider site (see inst				•		
5. 00 6. 00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther				hy therany	0	5. 0 6. 0
3. 00	assistant and on which supervisor and/or the						0.0
7. 00	instructions) Standard travel expense rate					6. 22	7.0
7. 00 3. 00	Optional travel expense rate per mile					0. 22	
		Supervi sors	Therapi sts	Assi stants		Trai nees	
9. 00	Total hours worked	1. 00	2. 00 1, 723. 00	3. 00 1, 051. (4. 00 00 0. 00	5. 00	9.00
10.00	AHSEA (see instructions)	0.00	89. 92	67.			
11. 00	Standard travel allowance (columns 1 and 2,	44. 96	44. 96	33.	72		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12. 00	,	0	0		0		12.00
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12. 0 13. 0
	Number of miles driven (offsite)	0	o o		Ö		13.0
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
4.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0 154, 932	
16. 00	Assistants (column 3, line 9 times column 3,					70, 879	16.0
17. 00	Subtotal allowance amount (sum of lines 14 a		atory therapy	or lines 14	-16 for all	225, 811	17.0
18 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18. 00
19. 00	Trainees (column 5, line 9 times column 5, l					Ö	19.0
20. 00	Total allowance amount (sum of lines 17-19 f						20.00
	If the sum of columns 1 and 2 for respirator occupational therapy, line 9, is greater tha						
	amount from line 20. Otherwise complete lin	es 21-23.					
21.00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,			n of columns	s I and 2, IIne 9	0.00	21.00
22. 00	Weighted allowance excluding aides and train					0	22. 0
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TDAVEL	EVDENSE COMDI	ITATI ON DE	ONVINED SITE	225, 811	23.00
	Standard Travel Allowance	WANCE AND TRAVEL	LAFLINGE COMP	JIAIIUN - FN	OVIDER SITE		
	Therapists (line 3 times column 2, line 11)					5, 755	
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for al	l others)		0 5, 755	25. 00 26. 00
27. 00	Standard travel expense (line 7 times line 3				3 and 4 for all	796	1
	others) Total standard travel allowance and standard	travel evnense	at the provide	er site (sum	of lines 26 and	6, 551	28.00
JR UU	27)	·	at the provide		1 01 111103 20 0110	0, 331	20.0
28. 00	Optional Travel Allowance and Optional Trave						
	Theranists (column 2 line 10 times the sum		1.2 line 12.)			0	20 0
29. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3	of columns 1 and	12, line 12)			0	
28. 00 29. 00 30. 00 31. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	of columns 1 and , line 12) sum of lines 29	and 30 for al			0	30. 00 31. 00
29. 00 30. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	of columns 1 and , line 12) sum of lines 29	and 30 for al		by or sum of	0	30. 00 31. 00
29. 00 80. 00 81. 00 82. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line	and 30 for al 13 for respira		oy or sum of	0	30. 00 31. 00 32. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	of columns 1 and , line 12) sum of lines 29 s 1 and 2, line I expense (line I expense (sum o	and 30 for all 13 for respira 28) If Lines 27 and	atory therap	oy or sum of	0 0 0 6, 551	30. 00 31. 00 32. 00 33. 00 34. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	and 30 for al 13 for respira 28) If lines 27 and If lines 31 and	atory therap d 31) d 32)		0 0 0 6, 551 0 0	30. 00 31. 00 32. 00 33. 00 34. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel Standard Travel Expense	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	and 30 for al 13 for respira 28) If lines 27 and If lines 31 and	atory therap d 31) d 32)		0 0 0 6, 551 0 0 ROVI DER SI TE	29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel Standard Travel Expense Therapists (line 5 times column 2, line 11)	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	and 30 for al 13 for respira 28) If lines 27 and If lines 31 and	atory therap d 31) d 32)		0 0 0 6, 551 0 0 ROVI DER SITE	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel Standard Travel Expense	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum o l expense (sum o	and 30 for al 13 for respira 28) If lines 27 and If lines 31 and	atory therap d 31) d 32)		0 0 0 6, 551 0 0 ROVI DER SI TE	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel allowance and optional travel Expense Therapists (line 5 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of lexpense) MANCE AND TRAVEL m of lines 5 and	and 30 for al 13 for respira 28) If lines 27 and If lines 31 and EXPENSE COMPU	atory therap d 31) d 32)		0 0 0 6, 551 0 0 ROVI DER SITE	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
29. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00 87. 00 88. 00 89. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel allowance and optional travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the supptional Travel Allowance and Optional Travel	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of l expense (sum of ANCE AND TRAVEL m of lines 5 and l Expense	and 30 for al 13 for respira 28) If lines 27 and If lines 31 and EXPENSE COMPU	atory therap d 31) d 32)		0 0 0 6, 551 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel allowance and optional travel Expense Therapists (line 5 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the supptional Travel Allowance and Optional Travel Expense (line 7 times the supptional Travel Allowance and Optional Travel	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of l expense (sum of ANCE AND TRAVEL m of lines 5 and l Expense O1 times column	and 30 for al 13 for respira 28) If lines 27 and If lines 31 and EXPENSE COMPU	atory therap d 31) d 32)		0 0 0 6, 551 0 0 ROVI DER SITE	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
29, 00 30, 00 31, 00 32, 00 33, 00 34, 00 35, 00 37, 00 38, 00 39, 00 40, 00 41, 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the supplicational Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of lexpense (sum of lines 5 and 1 Expense Of times column n 3, line 10)	and 30 for al 13 for respira 28) If lines 27 and If lines 31 and EXPENSE COMPU	atory therap d 31) d 32)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 37. 0 38. 0 39. 0 41. 0 42. 0
29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel allowance and optional travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12. O1 times column 3, line 12.	of columns 1 and, line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of l expense (sum of ANCE AND TRAVEL m of lines 5 and l Expense O1 times column n 3, line 10) m of columns 1-3	and 30 for all 13 for respiral 28) If lines 27 and Innes 31 and EXPENSE COMPUTED 16) 2, line 10)	atory therap d 31) d 32) FATION - SER	EVICES OUTSIDE PR	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	SALEM TOWNSHI FURNI SHED BY	Provider Co	CN: 14-1345	Peri od: From 04/01/2022	u of Form CMS-2 Worksheet A-8 Parts I-VI	
01310	E SUITELENS				To 03/31/2023	Date/Time Pre 8/29/2023 9:2	pared: O am
					Occupati onal	Cost	o am
					Therapy		
5 00	Optional travel allowance and standard travel	AVDADSA (SUM	of lines 30 au	nd 12 - see i	netructions)	1. 00	45.00
	Optional travel allowance and optional travel					0	
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	DADT W OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
7. 00	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not	0.00	0.00	0.0	0.00	0.00	47.0
	complete lines 48-55 and enter zero in each column of line 56)						
8. 00	Overtime rate (see instructions)	0.00	0.00	•			48.0
9. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0.00	0.0	0.00		49.0
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0.0	0.00	0.00	50. 0
1. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	0.00	0.00	51.0
	DETERMINATION OF OVERTIME ALLOWANCE			L			
	Adjusted hourly salary equivalency amount (see instructions)	89. 92	67. 44				52.0
3. 00 4. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53. 0 54. 0
5. 00	Maximum overtime cost (enter the lesser of line 49 or line 53) Portion of overtime already included in	0	0		0 0		55.0
	hourly computation at the AHSEA (multiply line 47 times line 52)						
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.0
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
7. 00	Salary equivalency amount (from line 23)					225, 811	
3. 00 9. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servio			4)		6, 551 0	58. 0 59. 0
	Overtime allowance (from column 5, line 56)	es (ITOIII TITIES	44, 45, 01 40	0)		0	60.0
	Equipment cost (see instructions)					Ö	
2. 00	Supplies (see instructions)					0	
. 00	Total allowance (sum of lines 57-62)					232, 362	63.0
. 00	Total cost of outside supplier services (from	n your records)				128, 984	64. (
. 00	Excess over limitation (line 64 minus line 63	3 - if negative	, enter zero)			0	65.0
nn nn	LINE 33 CALCULATION	sum of lines 2	4 and 25 for a	all others		5, 755	100 (
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27							100. 0 100. 0
	LINE 24 CALCHIATION						101 (
0. 02	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	/ therapy or su	m of lines 3 a	and 4 for all	others	796	
00. 02 01. 00 01. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others		101. C
00. 02 01. 00 01. 01 01. 02	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	sum of lines 2	9 and 30 for a	all others	others	0 796	101. C

Heal th	Financial Systems	SALEM TOWNSHI	P HOSPLTAL		In lie	u of Form CMS-2	2552-10							
REASON	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS		Provi der CC	CN: 14-1345	Peri od: From 04/01/2022 To 03/31/2023	Worksheet A-8 Parts I-VI Date/Time Pre	-3 pared:							
						8/29/2023 9: 2	0 am							
					Speech Pathology	Cost								
						1 00								
	DART I CENERAL INFORMATION					1. 00								
1. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide:	a) (aaa i natrus	ti ana)			8	1.00							
2. 00	Line 1 multiplied by 15 hours per week	s) (see mstruc	tions)			120	2.00							
3. 00	Number of unduplicated days in which supervi	cor or thoronic	t was an aroui	dor sita (so	o instructions)	120	3.00							
4. 00	Number of unduplicated days in which therapy	soi oi tilerapis	on provider si	to but poith	or supervisor	0	4.00							
4.00	nor therapist was on provider site (see inst	ei supei vi soi	U	4.00										
5. 00	Number of unduplicated offsite visits - supe		anists (see in	nstructions)		0	5.00							
6. 00	Number of unduplicated offsite visits - there				by therapy	0	6.00							
0.00	assistant and on which supervisor and/or the					· ·	0.00							
	instructions)	.,		,	,, (
7.00	Standard travel expense rate					6. 22	7.00							
8.00	Optional travel expense rate per mile					0.00	8.00							
		Trai nees												
		1. 00	2. 00	3. 00	4. 00	5. 00								
9. 00	Total hours worked	0. 00	34. 00	0.0		0. 00								
	AHSEA (see instructions)	0.00	86. 45	0. 0		0. 00								
11.00	Standard travel allowance (columns 1 and 2,	43. 23	43. 23	0.0	00		11.00							
	one-half of column 2, line 10; column 3,													
12. 00	one-half of column 3, line 10)		0		0		12 00							
	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12. 00 12. 01							
	Number of miles driven (provider site)	0	0		0		13.00							
	Number of miles driven (provider site)	0	0				13.00							
13. 01	Number of mires arriver (orrarte)	<u> </u>	<u> </u>		o _l		13.01							
						1. 00								
	Part II - SALARY EQUIVALENCY COMPUTATION													
14.00	Supervisors (column 1, line 9 times column 1	, line 10)				0	14.00							
15.00	Therapists (column 2, line 9 times column 2,	line 10)				2, 939	15.00							
16.00	Assistants (column 3, line 9 times column 3,	line10)				0	16.00							
17. 00	Subtotal allowance amount (sum of lines 14 a	nd 15 for respi	ratory therapy	or lines 14	-16 for all	2, 939	17.00							
	others)													
	Aides (column 4, line 9 times column 4, line					0	18. 00							
	Trainees (column 5, line 9 times column 5, l					0	19. 00							
20.00	Total allowance amount (sum of lines 17-19 fo					2, 939	20.00							
	If the sum of columns 1 and 2 for respiratory													
	occupational therapy, line 9, is greater than		no entries on	lines 21 and	22 and enter on	line 23 the								
04 00	amount from line 20. Otherwise complete line			6	4	0/ 11	04 00							
21. 00	Weighted average rate excluding aides and tr			ım of columns	1 and 2, Tine 9	86. 44	21. 00							
22.00	for respiratory therapy or columns 1 thru 3,					10 272	22.00							
22. 00	Weighted allowance excluding aides and train	ees (iine z tim	ies iine zi)			10, 373								
22 00	Total calary oquivaloney (con instructions)													
23. 00	Total salary equivalency (see instructions)	NANCE AND TRAVE	I EXDENSE COME	DITATION _ DD	OVIDER SITE	Total salary equivalency (see instructions) 10,373 23.00 PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								

	occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on amount from line 20. Otherwise complete lines 21-23.	line 23 the	
21 00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9	86. 44	21 00
21.00	for respiratory therapy or columns 1 thru 3, line 9 for all others)	00. 11	21.00
22 00	Weighted allowance excluding aides and trainees (line 2 times line 21)	10, 373	22 00
	Total salary equivalency (see instructions)	10, 373	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE	107070	20.00
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	346	24.00
	Assistants (line 4 times column 3, line 11)		25. 00
	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		26. 00
	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all		
	others)		
28. 00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and	396	28.00
	27)		
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	o	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	o	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	o	32.00
	columns 1-3, line 13 for all others)		
33.00	Standard travel allowance and standard travel expense (line 28)	396	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	o	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	o	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PR	OVI DER SITE	
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	o	37.00
38.00	Subtotal (sum of lines 36 and 37)	o	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	o	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	o	41.00
42.00	Subtotal (sum of lines 40 and 41)	o	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	o	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lin	es 44, 45, or	
	46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45.00

Health Financial Cyctems	CALEM TOWNSHILL	D HOCDITAL		la lio	u of Form CMC 1	DEED 10
Health Financial Systems REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS	SALEM TOWNSHII FURNI SHED BY	Provi der CO	CN: 14-1345	Period: From 04/01/2022 To 03/31/2023		-3 pared:
				Speech Pathology		
					1. 00	
46.00 Optional travel allowance and optional trave						46. 00
	Therapi sts 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5. 00	
PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
47.00 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	0.00	0.00	O. C	0.00	0.00	47.00
column of line 56) 48.00 Overtime rate (see instructions)	0.00	0.00	0. 0	0.00		48. 00
49.00 Total overtime (including base and overtime	0.00	0.00				49.00
allowance) (multiply line 47 times line 48)	0.00	0.00		0.00		17.00
CALCULATION OF LIMIT						
50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0. 00	0. 0	0.00	0.00	50.00
51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE	86. 45	0.00	0.0	0.00		52. 00
52.00 Adjusted hourly salary equivalency amount (see instructions)	80. 45	0.00	0.0	0.00		52.00
53.00 Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
54.00 Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55.00
line 47 times line 52) 56.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56. 00
respiratory therapy and columns 1 through 3 for all others.)						
Part VI - COMPUTATION OF THERAPY LIMITATION	AND EVERS COST	AD ILICTMENT			1. 00	
57.00 Salary equivalency amount (from line 23)	AND EXCESS COST	ADJUSTMENT			10, 373	57. 00
58.00 Travel allowance and expense - provider site	(from lines 33	. 34. or 35))			396	1
59.00 Travel allowance and expense - Offsite servi			6)		0	59.00
60.00 Overtime allowance (from column 5, line 56)					0	60.00
61.00 Equipment cost (see instructions)					0	61.00
62.00 Supplies (see instructions)					0	
63.00 Total allowance (sum of lines 57-62)						63.00
64.00 Total cost of outside supplier services (fro						64.00
65.00 Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION	3 - II negative	, enter zero)			0	65. 00
100.00 Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for :	all others		346	100.00
100.01 Line 27 = line 7 times line 3 for respirator				others	l .	100.01
100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION		0			l	100. 02
101.00 Line 27 = line 7 times line 3 for respirator				others		101. 00
101.01 Line 31 = line 29 for respiratory therapy or 101.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 2	9 and 30 for a	all others			101. 01 101. 02
102.00 Line 31 = line 29 for respiratory therapy or 102.01 Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
13 for all others 102.02 Line 35 = sum of lines 31 and 32					0	102. 02

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS SALEM TOWNSHIP HOSPITAL Provider CCN: 14-1345 CAPITAL RELATED COSTS

			CAPITAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	oost center bescription	for Cost	DEDG & TTAT	MIVEL EQUIT	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
	ENERAL OFFICE OFFICE	0	1. 00	2. 00	4. 00	4A	
	SENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1 540 051	1 540 051	I			1 00
	00200 CAP REL COSTS-BLDG & FIXT	1, 562, 351 1, 208, 550	1, 562, 351	1, 208, 550			1.00 2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 301, 481	10, 951		4, 320, 903		4.00
	00592 ADMINISTRATIVE & GENERAL	4, 908, 602			621, 530	6, 040, 081	5. 01
	00600 MAINTENANCE & REPAIRS	0	l ·		0	0	6.00
	00700 OPERATION OF PLANT	1, 117, 213	302, 381	233, 908	101, 833	1, 755, 335	7.00
8.00 0	00800 LAUNDRY & LINEN SERVICE	130, 144	8, 750	6, 769	28, 486	174, 149	8. 00
	00900 HOUSEKEEPI NG	424, 787	7, 270	5, 623	104, 695	542, 375	9. 00
	01000 DI ETARY	806, 686	48, 260	37, 332	167, 388	1, 059, 666	
	01100 CAFETERI A	0	1		0	0	11.00
	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	12.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	16, 798			4, 899 42, 216	25, 299	1
	11500 PHARMACY	138, 913 1, 681, 796			20, 538	220, 046 1, 729, 374	•
	11600 MEDICAL RECORDS & LIBRARY	448, 727	25, 624		116, 141	610, 313	
	1700 SOCIAL SERVICE	0			0	010, 313	
1	1900 NONPHYSI CI AN ANESTHETI STS	0	l		o	0	ı
	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 872, 188	220, 800	170, 799	756, 141	4, 019, 928	30.00
Α	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 893, 640	· ·		246, 421	2, 285, 884	1
	05300 ANESTHESI OLOGY	0			0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 186, 639			234, 741	1, 550, 217	
	05700 CT SCAN 05800 MRI	239, 776 32, 078			30, 287	281, 016	1
	06000 LABORATORY	2, 673, 074	l '		23, 727 255, 066	63, 777 3, 013, 424	•
	06500 RESPI RATORY THERAPY	535, 347	45, 179		136, 905	752, 379	
	06600 PHYSI CAL THERAPY	658, 193	l '		0	762, 025	
	06700 OCCUPATI ONAL THERAPY	95, 099			o	111, 990	1
	06800 SPEECH PATHOLOGY	1, 825	l '		0	1, 825	1
	06900 ELECTROCARDI OLOGY	54, 127	0	0	14, 772	68, 899	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	494, 922		0	0	494, 922	
	07200 I MPL. DEV. CHARGED TO PATIENTS	449, 978	l e	-	0	449, 978	
	07300 DRUGS CHARGED TO PATIENTS	-2, 728			0	-2, 728	
	03550 BEHAVI ORAL HEALTH OUTPATI ENT SERVI CE COST CENTERS	337, 432	10, 578	8, 182	61, 137	417, 329	76. 00
	08800 RURAL HEALTH CLINIC	1, 984, 839	53, 609	41, 469	427, 448	2, 507, 365	88. 00
	08801 RURAL HEALTH CLINIC II	1, 328, 621	48, 340		358, 925	1, 773, 279	
	99000 CLI NI C	282, 073			73, 568	406, 930	1
	99001 SALEM MEDICAL CLINIC	0	0		0	0	90. 01
	99100 EMERGENCY	2, 794, 459	55, 877	43, 223	464, 592	3, 358, 151	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	PECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	34, 657, 630	1, 474, 981	1, 140, 965	4, 291, 456	34, 473, 228	118.00
	ONREIMBURSABLE COST CENTERS 9000 GIFT FLOWER COFFEE SHOP & CANTEEN		0		ol	0	190. 00
	9200 PHYSI CLANS PRI VATE OFFI CES	75, 888			21, 073	251, 916	1
	9201 TEMPORALLY IDLE SPACE	0	0,,0,0	0,,000	21, 0, 0		192. 01
	9202 STH FAM HLTH CRT	-14, 957	Ö	Ö	ol	-14, 957	
	9203 RI SE OUTREACH LAB	0	0	0	o		192. 03
	07950 LITIGATION COSTS	0	0	0	O		194. 00
	07951 MT VERNON SURGICAL CLINIC	34, 537	0	0	8, 374	42, 911	
200.00	Cross Foot Adjustments		_				200.00
201.00	Negative Cost Centers	24 750 000	0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	34, 753, 098	1, 562, 351	1, 208, 550	4, 320, 903	34, 753, 098	J202. 00

Provider CCN: 14-1345

| Peri od: | Worksheet B | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared:

				!	0 03/31/2023	8/29/2023 9: 2	
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	5551 551151 55551 Pt. 511	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUGENEEL THO	
		5. 01	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	•		•			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00592 ADMINISTRATIVE & GENERAL	6, 040, 081					5. 01
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7. 00	00700 OPERATION OF PLANT	369, 026	0	2, 124, 361			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	36, 612	0	19, 302	230, 063		8.00
9. 00	00900 HOUSEKEEPI NG	114, 024	0	16, 036	0	672, 435	9.00
10.00	01000 DI ETARY	222, 775	n	106, 455	ام	34, 267	ł
11. 00	01100 CAFETERI A	0	0	0	ام	01, 207	ı
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	٥	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	5, 319	0	·	ol ol	2, 557	•
14. 00	01400 CENTRAL SERVICES & SUPPLY	46, 260	0			15, 580	1
15. 00	01500 PHARMACY	363, 568	0			10, 826	1
16.00	01600 MEDICAL RECORDS & LIBRARY	128, 307	0		0	18, 194	ł
17. 00	01700 SOCIAL SERVICE	120, 307	0		0	10, 194	17.00
17.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19.00
19.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	U		U U	U	19.00
20.00		845, 110		487, 050	230, 063	154 775	20.00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	845, 110	0	487,050	230, 003	156, 775	30.00
50.00	05000 OPERATING ROOM	480, 564	0	181, 368	ol	58, 380	50.00
53. 00	05300 ANESTHESI OLOGY	480, 304	0		0	0.00	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	325, 904	0	1	0	-	•
57.00	05700 CT SCAN		0	160, 241	٥	51, 580	•
		59, 078	0	13, 623	U	4, 385	•
58. 00	05800 MRI	13, 408	0	9, 916	0	3, 192	
60.00	06000 LABORATORY	633, 515	0	106, 072	0	34, 144	1
65.00	06500 RESPI RATORY THERAPY	158, 173	0	99, 658	0	32, 079	
66.00	06600 PHYSI CAL THERAPY	160, 201	0		0	41, 569	
67. 00	06700 OCCUPATI ONAL THERAPY	23, 544	0	21, 009	0	6, 762	•
68. 00	06800 SPEECH PATHOLOGY	384	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	14, 485	0	0	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	104, 048	0	0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	94, 599	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
76. 00	03550 BEHAVI ORAL HEALTH	87, 735	0	23, 333	0	7, 511	76.00
	OUTPATIENT SERVICE COST CENTERS				_1		
88. 00	08800 RURAL HEALTH CLINIC	527, 126			0	38, 065	•
88. 01	08801 RURAL HEALTH CLINIC II	372, 798	0		0	34, 324	1
90.00	09000 CLINIC	85, 549	0		0	20, 534	1
90. 01	09001 SALEM MEDICAL CLINIC	0	0	0	0	0	90. 01
91. 00	09100 EMERGENCY	705, 987	0	123, 256	0	39, 675	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		5, 978, 099	0	1, 931, 636	230, 063	610, 399	118.00
400.00	NONREI MBURSABLE COST CENTERS	1		_			
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0					190.00
	19200 PHYSICIANS PRIVATE OFFICES	52, 961	0	192, 725	0		192.00
	19201 TEMPORALLY I DLE SPACE	0	0	0	0		192. 01
	19202 STH FAM HLTH CRT	0	0	0	0		192. 02
	19203 RI SE OUTREACH LAB	0	0	0	0		192. 03
	07950 LITIGATION COSTS	0	0	0	0		194. 00
194. 01	07951 MT VERNON SURGICAL CLINIC	9, 021	0	0	0	0	194. 01
200.00							200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	6, 040, 081	0	2, 124, 361	230, 063	672, 435	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| Peri od: | Worksheet B | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared:

			'	0 03/31/2023	8/29/2023 9: 2	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	<u> </u>
			OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
				N	SUPPLY	
	10.00	11. 00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS				'		
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00592 ADMINISTRATIVE & GENERAL						5. 01
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	1, 423, 163					10.00
11. 00 01100 CAFETERI A	o	0				11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	1 (12.00
13.00 01300 NURSING ADMINISTRATION	ol	0		41, 119		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	ol	0	1	0	330, 288	14. 00
15. 00 01500 PHARMACY	0	0			1, 986	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	ol	0	1		1, 504	16. 00
17. 00 01700 SOCI AL SERVI CE	ol	0	1		0	17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	0	0		-	0	19. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>			,ı		. , , , , ,
30. 00 03000 ADULTS & PEDIATRICS	1, 423, 163	0	C	13, 019	28, 243	30. 00
ANCILLARY SERVICE COST CENTERS	17 1207 100				20/210	00.00
50. 00 05000 OPERATING ROOM	0	0		4, 243	105, 567	50.00
53. 00 05300 ANESTHESI OLOGY	0	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	ol	0	1		22, 770	54.00
57. 00 05700 CT SCAN	ol	0	1		10, 819	57. 00
58. 00 05800 MRI	ol	0	1		2, 043	58.00
60. 00 06000 LABORATORY	ol	0	1		0	60.00
65. 00 06500 RESPIRATORY THERAPY	ol	0	1		5, 027	65.00
66. 00 06600 PHYSI CAL THERAPY	ol	0	1		2, 042	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	ol	0	1	ا ا	376	67.00
68. 00 06800 SPEECH PATHOLOGY	ol	0	1	ا ا	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0		ol ol	279	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		ol ol	1, 452	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0		ol ol	102, 946	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	ő	0		ol ol	0	73.00
76. 00 03550 BEHAVI ORAL HEALTH	o	0			835	76.00
OUTPATIENT SERVICE COST CENTERS	9			., ., .,		70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0		7, 359	5, 689	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	ol	0	1		5, 963	88. 01
90. 00 09000 CLINIC	Ö	0	1	1, 267	4, 008	90.00
90. 01 09001 SALEM MEDICAL CLINIC	ol	0	1		0	90. 01
91. 00 09100 EMERGENCY	ol	0	1	7, 999	28, 263	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	٩	ŭ		.,,,,	20, 200	92.00
SPECIAL PURPOSE COST CENTERS						72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 423, 163	0		41, 119	329, 812	118 00
NONREI MBURSABLE COST CENTERS	1, 423, 103			,	327, 012	110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	C	ol	0	190. 00
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0				192.00
192. 01 19201 TEMPORALLY IDLE SPACE	ő	0				192.01
192. 02 19202 STH FAM HLTH CRT	0	0		1		192. 02
192. 03 19203 RI SE OUTREACH LAB	0	0		ή		192. 03
194. 00 07950 LITIGATION COSTS	n	0		1		194. 00
194. 01 07951 MT VERNON SURGICAL CLINIC	0	0	`	1 1		194. 00
200.00 Cross Foot Adjustments	٩	0		1	10	200.00
201.00 Negative Cost Centers	n	0		ار	Λ	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 423, 163	0		I I	330, 288	202.00
	., .25, 100	O		1	223, 200	

| Peri od: | Worksheet B | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1345

					To 03/31/2023	Date/Time Pre 8/29/2023 9:2	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	Subtotal	O alli
	goot conton pood. The on		RECORDS &	SERVI CE	ANESTHETI STS		
			LI BRARY				
		15. 00	16. 00	17.00	19.00	24.00	
	NERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FLXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
1	0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	D592 ADMINISTRATIVE & GENERAL						5. 01
	0600 MAINTENANCE & REPAIRS						6.00
	0700 OPERATION OF PLANT						7.00
	0800 LAUNDRY & LINEN SERVICE						8. 00
	0900 HOUSEKEEPI NG						9.00
	1000 DI ETARY 1100 CAFETERI A						10.00
	1200 MAINTENANCE OF PERSONNEL						11. 00 12. 00
	1300 NURSING ADMINISTRATION						13.00
1	1400 CENTRAL SERVICES & SUPPLY						14.00
1	1500 PHARMACY	2, 139, 385					15.00
	1600 MEDICAL RECORDS & LIBRARY	2, 137, 303	814, 841				16.00
	1700 SOCIAL SERVICE	0	014,041		o		17.00
	1900 NONPHYSI CLAN ANESTHETI STS	o o	0	•	o o		19.00
	IPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			<u> </u>		
	3000 ADULTS & PEDIATRICS	0	67, 729		0 0	7, 271, 080	30.00
	ICILLARY SERVICE COST CENTERS	1	·		<u>'</u>		
50.00 05	5000 OPERATING ROOM	0	93, 423		0 0	3, 209, 429	50.00
	5300 ANESTHESI OLOGY	0	0		0	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	0	67, 641		0	2, 178, 353	54.00
	5700 CT SCAN	0	123, 768		0	492, 689	1
	5800 MRI	0	16, 831		0	107, 107	1
	5000 LABORATORY	0	180, 367		0	-, ,	
	5500 RESPIRATORY THERAPY	0	26, 252		0	1,0,0,000	1
1	6600 PHYSI CAL THERAPY	0	24, 064	1	0	1, 119, 042	1
	5700 OCCUPATIONAL THERAPY 5800 SPEECH PATHOLOGY	0	4, 911	1	0 0	168, 592	1
	5900 ELECTROCARDI OLOGY		26 13, 216	•		2, 235 96, 879	1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6, 738		0 0	607, 160	1
	7200 IMPL. DEV. CHARGED TO PATIENTS		4, 279		0 0		1
	7300 DRUGS CHARGED TO PATIENTS	2, 139, 385	27, 722		o o		1
	B550 BEHAVI ORAL HEALTH	2, 107, 000	4, 732		o o	, , , , , , , , , , , , , , , , , , , ,	1
	JTPATIENT SERVICE COST CENTERS	· ·	.,				
88. 00 08	3800 RURAL HEALTH CLINIC	0	18, 209		0 0	3, 222, 067	88. 00
88. 01 08	B801 RURAL HEALTH CLINIC II	0	8, 042		0	2, 307, 216	88. 01
90.00 09	9000 CLI NI C	0	5, 945		0	588, 024	90.00
	9001 SALEM MEDICAL CLINIC	0	0		0	_	90. 01
	P100 EMERGENCY	0	120, 946		0	4, 384, 277	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	PECIAL PURPOSE COST CENTERS	0.400.005	014 044			24.457.000	440.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	2, 139, 385	814, 841		0 0	34, 156, 009]118.00
	2000 GIFT FLOWER COFFEE SHOP & CANTEEN	ol	0		0 0		190. 00
	P200 PHYSICIANS PRIVATE OFFICES	0	0		0 0	_	
	2200 PHYSICIANS PRIVATE OFFICES 2201 TEMPORALLY IDLE SPACE		0	•			192.00
	2202 STH FAM HLTH CRT	0	0		o o	l	192.02
	2203 RISE OUTREACH LAB	ا	0	1	o o		192.03
	7950 LITIGATION COSTS	l ol	0	i .	o o		194. 00
	7951 MT VERNON SURGICAL CLINIC	o	0		0		194. 01
200.00	Cross Foot Adjustments				0		200. 00
201. 00	Negative Cost Centers	0	0		0		201.00
202.00	TOTAL (sum lines 118 through 201)	2, 139, 385	814, 841		0 0	34, 753, 098	202.00

Health Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1345 Period: Worksheet B

From 04/01/2022 Part I 03/31/2023 Date/Time Prepared: 8/29/2023 9: 20 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00592 ADMINISTRATIVE & GENERAL 5.01 5.01 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 | 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 7, 271, 080 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3, 209, 429 50.00 05300 ANESTHESI OLOGY 53.00 0 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 2, 178, 353 54.00 05700 CT SCAN 57.00 492, 689 57.00 58. 00 05800 MRI 109, 167 58.00 06000 LABORATORY 60.00 00000000 3, 967, 522 60.00 06500 RESPIRATORY THERAPY 65 00 1,073,568 65 00 06600 PHYSI CAL THERAPY 66.00 1, 119, 042 66.00 06700 OCCUPATI ONAL THERAPY 168, 592 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 2, 235 68.00 06900 ELECTROCARDI OLOGY 96, 879 69 00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 607, 160 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 651, 802 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 164, 379 73.00 03550 BEHAVI ORAL HEALTH 542, 528 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 3, 222, 067 88.00 0 08801 RURAL HEALTH CLINIC II 2, 307, 216 88.01 88.01 09000 CLI NI C 90 00 588, 024 90.00 90.01 09001 SALEM MEDICAL CLINIC 0 90.01 09100 EMERGENCY 0 4, 384, 277 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 34, 156, 009 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 560,089 192.00 192. 01 19201 TEMPORALLY IDLE SPACE 00000 192.01 192.02 19202 STH FAM HLTH CRT -14, 948 192.02 192. 03 19203 RISE OUTREACH LAB r 192.03 194.00 07950 LITIGATION COSTS 194.00 194. 01 07951 MT VERNON SURGICAL CLINIC 51, 948 194.01 200.00 200.00 Cross Foot Adjustments C 201.00 Negative Cost Centers 0 201.00 TOTAL (sum lines 118 through 201) 202.00 34, 753, 098 202.00

| Peri od: | Worksheet B | From 04/01/2022 | Part II | To 03/31/2023 | Date/Time Prepared: Provider CCN: 14-1345

				То	03/31/2023	Date/Time Pre 8/29/2023 9:2	
			CAPI TAL REI	LATED COSTS		072772023 7.2	O alli
			57.1. 7.7.E 1.E.	211125 00010			
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1. 00	2. 00	2A	4. 00	
	ENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP		40.054	0 474	40.400	40, 400	2.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT	0	10, 951		19, 422	19, 422	4.00
1	00592 ADMINISTRATIVE & GENERAL	0	285, 960		509, 949	2, 794	5. 01
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0 302, 381	1	F24 200	0	6.00
	00800 LAUNDRY & LINEN SERVICE	0	8, 750		536, 289 15, 519	458 128	7. 00 8. 00
1	00900 HOUSEKEEPING	0	7, 270	1	12, 893	471	9.00
	1000 DI ETARY	0	48, 260	1	85, 592	752	10.00
	1100 CAFETERI A	0	40, 200		03, 372	0	11.00
1	01200 MAINTENANCE OF PERSONNEL	0	0	_	Ö	0	12.00
	01300 NURSI NG ADMI NI STRATI ON	0	3, 602		3, 602	22	13.00
	11400 CENTRAL SERVICES & SUPPLY	0	21, 943	1	38, 917	190	14.00
	1500 PHARMACY	0	15, 246	1	27, 040	92	15. 00
1	01600 MEDICAL RECORDS & LIBRARY	0	25, 624	1	45, 445	522	16.00
	01700 SOCIAL SERVICE	0	0		0	0	17.00
	1900 NONPHYSICIAN ANESTHETISTS	0	0	0	o	0	19.00
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	220, 800	170, 799	391, 599	3, 399	30.00
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	82, 221		145, 823	1, 108	50.00
	D5300 ANESTHESI OLOGY	0	0		0	0	53.00
	D5400 RADI OLOGY-DI AGNOSTI C	0	72, 644		128, 837	1, 055	54.00
	05700 CT SCAN	0	6, 176		10, 953	136	57.00
	05800 MRI	0	4, 495		7, 972	107	58.00
	06000 LABORATORY	0	48, 087		85, 284	1, 146	60.00
	06500 RESPI RATORY THERAPY	0	45, 179		80, 127	615	65.00
1	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	58, 545		103, 832	0	66.00
	16800 SPEECH PATHOLOGY	0	9, 524	7, 367	16, 891 0	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	66	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	o o	ol	0	73.00
	03550 BEHAVI ORAL HEALTH	0	10, 578	8, 182	18, 760	275	76. 00
	UTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	53, 609	41, 469	95, 078	1, 921	88. 00
88. 01 0	08801 RURAL HEALTH CLINIC II	0	48, 340	37, 393	85, 733	1, 613	88. 01
	99000 CLI NI C	0	28, 919	22, 370	51, 289	331	90.00
90. 01	99001 SALEM MEDICAL CLINIC	0	0	0	0	0	90. 01
91.00	9100 EMERGENCY	0	55, 877	43, 223	99, 100	2, 088	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	PECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 474, 981	1, 140, 965	2, 615, 946	19, 289	118. 00
	ONREI MBURSABLE COST CENTERS	1			ما		
	9000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	07.070	0	0		190.00
	9200 PHYSI CLANS PRI VATE OFFI CES	0	87, 370	67, 585	154, 955		192.00
	9201 TEMPORALLY IDLE SPACE	0	0		O		192. 01 192. 02
	9202 STH FAM HLTH CRT 9203 RISE OUTREACH LAB		0	0	O O		192. 02 192. 03
	9203 RISE OUTREACH LAB 07950 LITIGATION COSTS		0		0		194. 00
	17950 ETTTGATTON COSTS 17951 MT VERNON SURGICAL CLINIC		0		٥		194. 00
200. 00	Cross Foot Adjustments			1	0		200.00
201.00	Negative Cost Centers		0		0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 562, 351	1, 208, 550	2, 770, 901		202.00
55	, (1	., 552, 561	., _55, 550	=,	. , , , , , , , , , , , , , , , , , , ,	,

Provider CCN: 14-1345

				'	0 00/01/2020	8/29/2023 9: 2	0 am
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 01	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00592 ADMINI STRATI VE & GENERAL	512, 743					5. 01
6.00	00600 MAINTENANCE & REPAIRS	o	0				6.00
7.00	00700 OPERATION OF PLANT	31, 327	0	568, 074			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	3, 108	0	5, 162	23, 917		8.00
9. 00	00900 HOUSEKEEPI NG	9, 680	0	4, 288		27, 332	9.00
10.00	01000 DI ETARY	18, 912	0		0	1, 393	1
11. 00	01100 CAFETERI A	0	0	0	0	0	11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL		0	0	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	452	0	2, 124	0	104	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 927	0	12, 943	0	633	
15. 00	01500 PHARMACY	30, 864	0	8, 993	0	440	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	10, 892	0	15, 115	0	740	
17. 00	01700 SOCIAL SERVICE	10, 672	0	15, 119	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS		0		0	0	
19.00		l ol	U		U	U	19.00
30. 00	I NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	71, 728	0	130, 243	23, 917	6, 370	30.00
30.00		/1, /28	U	130, 243	23, 917	0, 370	30.00
EO 00	ANCILLARY SERVICE COST CENTERS	40.704	0	40.400	٥	2 272	 EO OO
50.00	05000 OPERATING ROOM	40, 796	0		0	2, 373	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	27, 667	0		0	2, 097	54.00
57. 00	05700 CT SCAN	5, 015	0	3, 643	0	178	57.00
58.00	05800 MRI	1, 138	0	2, 652	0	130	58. 00
60.00	06000 LABORATORY	53, 781	0	28, 365	0	1, 388	1
65.00	06500 RESPI RATORY THERAPY	13, 428	0	26, 649	0	1, 304	65.00
66. 00	06600 PHYSI CAL THERAPY	13, 600	0	34, 533	0	1, 690	1
67.00	06700 OCCUPATI ONAL THERAPY	1, 999	0	5, 618	0	275	67. 00
68.00	06800 SPEECH PATHOLOGY	33	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 230	0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 833	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	8, 031	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550 BEHAVI ORAL HEALTH	7, 448	0	6, 239	0	305	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	44, 749	0	31, 622	0	1, 547	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	31, 648	0	28, 514	0	1, 395	88. 01
90.00	09000 CLI NI C	7, 262	0	17, 058	0	835	90.00
90. 01	09001 SALEM MEDICAL CLINIC	0	0	0	0	0	90. 01
91.00	09100 EMERGENCY	59, 933	0	32, 960	0	1, 613	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	507, 481	0	516, 537	23, 917	24, 810	118.00
	NONREI MBURSABLE COST CENTERS	· · · · · ·			· ·		
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSICIANS PRIVATE OFFICES	4, 496	0	51, 537	0	2, 522	192.00
	19201 TEMPORALLY IDLE SPACE	0	0	0	0		192. 01
	19202 STH FAM HLTH CRT	o	0	Ö	0		192. 02
	19203 RI SE OUTREACH LAB	0	0	0	0		192. 03
	07950 LITIGATION COSTS		0	١	n		194.00
	07951 MT VERNON SURGICAL CLINIC	766	0		ام		194. 01
200.00	l l	700	J			O	200.00
200.00	1 1	0	0	_	۸	0	201.00
201.00	1 9	512, 743	0	568, 074	23, 917	27, 332	
202.00	ITOTAL (Suil TITIES TTO LITTOUGH 201)	512, 743	U	1 500,074	23, 917	21, 332	1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1345

				1	0 03/31/2023	8/29/2023 9: 2	
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	
					ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		10. 00	11. 00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00592 ADMINISTRATIVE & GENERAL						5. 01
	00600 MAINTENANCE & REPAIRS						6. 00
1	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY	135, 116					10.00
	01100 CAFETERI A	0	0				11. 00
	01200 MAINTENANCE OF PERSONNEL	0	0	0			12. 00
	01300 NURSING ADMINISTRATION	0	0	0	6, 304		13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	56, 610	14. 00
1	01500 PHARMACY	0	0	0	0	340	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	258	16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
1	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	135, 116	0	0	1, 994	4, 841	30.00
	NCILLARY SERVICE COST CENTERS						
1	05000 OPERATING ROOM	0	0			18, 093	50.00
	05300 ANESTHESI OLOGY	0	0		_	0	53.00
1	D5400 RADI OLOGY-DI AGNOSTI C	0	0	0		3, 903	54.00
1	D5700 CT SCAN	0	0	0	-	1, 854	57.00
	05800 MRI	0	0	0	-	350	
1	06000 LABORATORY	0	0	0	-	0	60.00
	06500 RESPI RATORY THERAPY	0	0	0	_	862	65.00
	06600 PHYSI CAL THERAPY	0	0	0	0	350	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	64	67.00
1	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	48	69.00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	249	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	17, 645	1
	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00
	03550 BEHAVI ORAL HEALTH	U	0	0	161	143	76.00
	OUTPATIENT SERVICE COST CENTERS	٥		1 0	1 120	075	00.00
	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II		0	0		975 1, 022	
	09000 CLINIC	0	0		194	687	90.00
1	09001 SALEM MEDICAL CLINIC	0	0			087	90.00
	09100 EMERGENCY	0	0	0	-	4, 844	91.00
1	09200 OBSERVATION BEDS (NON-DISTINCT PART	U	U	0	1, 227	4, 844	91.00
	SPECIAL PURPOSE COST CENTERS						92.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	135, 116	0	0	6, 304	56 528	118. 00
H-	IONREI MBURSABLE COST CENTERS	133, 110			0, 304	30, 320	1110.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	0	0	1			192. 00
1	19201 TEMPORALLY IDLE SPACE	n o	0				192.01
	19202 STH FAM HLTH CRT	n o	0		_		192.02
	19203 RISE OUTREACH LAB	n o	0				192. 03
	07950 LITIGATION COSTS	n o	0				194. 00
1	07951 MT VERNON SURGICAL CLINIC	n o	0		-		194. 01
200.00	Cross Foot Adjustments	Ĭ	O	I			200.00
201.00	Negative Cost Centers	o	0	0	0	n	201.00
202.00	TOTAL (sum lines 118 through 201)	135, 116	0			56, 610	202.00
00	, (. 55, 6	O	1	5,501	55,510	,

| Peri od: | Worksheet B | From 04/01/2022 | Part II | To 03/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1345

				1	o 03/31/2023	Date/Time Pre	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	Subtotal	.o aiii
			RECORDS &	SERVI CE	ANESTHETI STS		
			LI BRARY				
		15. 00	16. 00	17. 00	19. 00	24.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00592 ADMI NI STRATI VE & GENERAL						5. 01
6.00	00600 MAI NTENANCE & REPAI RS						6.00
	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
	01100 CAFETERI A						11.00
	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMINI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY	67, 769					15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	72, 972				16.00
	01700 SOCIAL SERVICE	0	. 0	1)		17.00
	01900 NONPHYSICIAN ANESTHETISTS	0	0		0		19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	6, 069	C)	775, 276	30.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	8, 371	(265, 714	50.00
	05300 ANESTHESI OLOGY	0	0			0	
	05400 RADI OLOGY-DI AGNOSTI C	0	6, 061	C		212, 470	1
	05700 CT SCAN	0	11, 090			32, 869	1
	05800 MRI	0	1, 508	1		13, 857	1
	06000 LABORATORY	O O	16, 121			186, 085	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	2, 352			125, 337	1
	06700 OCCUPATIONAL THERAPY	0	2, 156 440			156, 161 25, 287	1
	06800 SPEECH PATHOLOGY	0	2			35	1
	06900 ELECTROCARDI OLOGY	0	1, 184	1		2, 528	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	604			9, 686	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	383	•		26, 059	1
	07300 DRUGS CHARGED TO PATIENTS	67, 769	2, 484			70, 253	1
	03550 BEHAVI ORAL HEALTH	0	424)	33, 755	1
	OUTPATIENT SERVICE COST CENTERS			•			1
88.00	08800 RURAL HEALTH CLINIC	0	1, 632	C)	178, 653	88. 00
	08801 RURAL HEALTH CLINIC II	0	721	C)	151, 594	88. 01
	09000 CLI NI C	0	533	()	78, 189	90.00
	09001 SALEM MEDICAL CLINIC	0	0	-		0	
	09100 EMERGENCY	0	10, 837	C)	212, 602	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
440.00	SPECIAL PURPOSE COST CENTERS	(2.2(0)	70.070			0.557.440	
118. 00		67, 769	72, 972		0	2, 556, 410	1118.00
	NONREI MBURSABLE COST CENTERS	0	0		\	1 0	100.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	0	0		1	213, 682	190.00
	19200 PHYSICIANS PRIVATE OFFICES 19201 TEMPORALLY IDLE SPACE	0	0	•			192.00
	19202 STH FAM HLTH CRT	0	0				192.02
	19203 RISE OUTREACH LAB	ol Ol	0				192.02
	07950 LITIGATION COSTS	ol O	0				194. 00
	07951 MT VERNON SURGICAL CLINIC	ol	0				194. 01
200.00		1	_		0	0	200.00
201.00	,	o	0	C	0		201.00
202.00	TOTAL (sum lines 118 through 201)	67, 769	72, 972	(0	2, 770, 901	202.00

Health Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1345 Period: Worksheet B

From 04/01/2022 Part II 03/31/2023 Date/Time Prepared: 8/29/2023 9: 20 am Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00592 ADMINISTRATIVE & GENERAL 5.01 5.01 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 775, 276 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 265, 714 50.00 05300 ANESTHESI OLOGY 53.00 0 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 212, 470 54.00 05700 CT SCAN 32, 869 57.00 57.00 58. 00 | 05800 MRI 13, 857 58.00 06000 LABORATORY 00000000 60.00 186, 085 60.00 06500 RESPIRATORY THERAPY 65 00 125, 337 65 00 06600 PHYSI CAL THERAPY 66.00 156, 161 66.00 67.00 06700 OCCUPATI ONAL THERAPY 25, 287 67.00 06800 SPEECH PATHOLOGY 68.00 35 68.00 69.00 06900 ELECTROCARDI OLOGY 2 528 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 9, 686 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 26, 059 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 70, 253 73.00 03550 BEHAVI ORAL HEALTH 0 33, 755 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 178, 653 88.00 0 08801 RURAL HEALTH CLINIC II 88.01 151.594 88.01 09000 CLI NI C 90 00 78, 189 90.00 90.01 09001 SALEM MEDICAL CLINIC 0 90.01 09100 EMERGENCY 0 91.00 91.00 212, 602 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 2, 556, 410 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 190 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 213, 682 192.00 192. 01 19201 TEMPORALLY IDLE SPACE 192. 01 00000 0 192.02 19202 STH FAM HLTH CRT 192.02 2 192. 03 19203 RISE OUTREACH LAB 0 192. 03 194.00 07950 LITIGATION COSTS C 194.00 194. 01 07951 MT VERNON SURGICAL CLINIC 194.01 807 Cross Foot Adjustments 200.00 200.00 C 0 201.00 Negative Cost Centers 201.00 C TOTAL (sum lines 118 through 201) 202.00 202.00 2, 770, 901

CU31 F	LLUCATION - STATISTICAL DASIS		Provider C		From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9: 2	
		CAPI TAL REL	ATED COSTS			7, 27, 2828 7, 2	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1.00	2.00	4. 00	5A. 01	5. 01	
4 00	GENERAL SERVICE COST CENTERS	117.407		1		T	
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP	117, 127	117, 127				1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	821	821	1	4		4.00
5. 01	00592 ADMINISTRATIVE & GENERAL	21, 438	21, 708			28, 730, 702	5. 01
6.00	00600 MAINTENANCE & REPAIRS	0	0	1	0 0	0	6.00
7.00	00700 OPERATION OF PLANT	22, 669	22, 669			,	
8. 00	00800 LAUNDRY & LI NEN SERVI CE	656	656	1			
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	545 3, 618	545 3, 618	1		,	1
11. 00	01100 CAFETERI A	3,010	3,010	1	0 0	1,034,000	1
12. 00	01200 MAINTENANCE OF PERSONNEL	0	Ō		o o	0	1
13.00	01300 NURSING ADMINISTRATION	270	0	15, 96		,	
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 645	1, 645			,	1
15.00	01500 PHARMACY	1, 143	1, 143				1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 921	1, 921 0	1	9 0 0	,	1
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0		
171.00	INPATIENT ROUTINE SERVICE COST CENTERS			1	<u> </u>		17.00
30.00	03000 ADULTS & PEDIATRICS	16, 553	16, 553	2, 464, 62	0 0	4, 019, 928	30.00
	ANCILLARY SERVICE COST CENTERS				.1	0 005 004	
50. 00 53. 00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	6, 164 0	6, 164 0				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 446	5, 446	1			
57. 00	05700 CT SCAN	463	463	1			
58.00	05800 MRI	337	337				
60.00	06000 LABORATORY	3, 605	3, 605	1			
65.00	06500 RESPI RATORY THERAPY	3, 387	3, 387				
66.00	06600 PHYSI CAL THERAPY	4, 389	4, 389	1	0		
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	714	714		0 0		
69. 00	06900 ELECTROCARDI OLOGY	0	Ö	48, 15	-	68, 899	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 0		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	100.07	0 2, 728		
76. 00	03550 BEHAVI ORAL HEALTH OUTPATI ENT SERVI CE COST CENTERS	793	793	199, 27	4 0	417, 329	76.00
88. 00	08800 RURAL HEALTH CLINIC	4, 019	4, 019	1, 393, 25	6 0	2, 507, 365	88.00
88. 01	08801 RURAL HEALTH CLINIC II	3, 624	3, 624				1
90.00	09000 CLI NI C	2, 168	2, 168	239, 79	2 0	406, 930	
90. 01	09001 SALEM MEDICAL CLINIC	0	0		0		
	09100 EMERGENCY	4, 189	4, 189	1, 514, 32	5 0	3, 358, 151	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00		110, 577	110, 577	13, 987, 88	4 -6, 037, 353	28, 435, 875	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	1	0		190.00
	19200 PHYSICIANS PRIVATE OFFICES	6, 550	6, 550	68, 68	6 0		
	19201 TEMPORALLY IDLE SPACE 19202 STH FAM HLTH CRT	0	0		0 14, 957		192. 01 192. 02
	19203 RISE OUTREACH LAB	0	0	1	0 14, 737		192.02
	07950 LITIGATION COSTS	0	0		0 0		194.00
	07951 MT VERNON SURGICAL CLINIC	0	0	27, 29	4 0	42, 911	194. 01
200.00							200.00
201. 00 202. 00	1 1 3	1, 562, 351	1, 208, 550	4, 320, 90	2	6, 040, 081	201.00
202.00	Part I)	1, 302, 331	1, 200, 550	4, 320, 90	3	0, 040, 001	202.00
203.00	1 1 1	13. 338948	10. 318287	0. 30679	8	0. 210231	203.00
204.00	Cost to be allocated (per Wkst. B,			19, 42	2	512, 743	204. 00
005 05	Part II)			0.0015-		0.0170:-	005 00
205.00	Unit cost multiplier (Wkst. B, Part			0. 00137	9	0. 017847	205.00
206.00	1 1 7						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Heal th Financial Systems

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1345

Provider CCN: 14-1345

Period:
From 04/01/2022
To 03/31/2023

Date/Time Prepared:
8/29/2023 9: 20 am

MAINTENANCE & OPERATION OF PLANT (SQUARE FEET)

(SQUARE FEET)

(SQUARE FEET)

(SQUARE FEET)

GENERAL SERVICE COST CENTERS

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (PATI ENT	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	O alli
		6. 00	7. 00	DAYS) 8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00592 ADMINISTRATIVE & GENERAL						5. 01
6.00	00600 MAI NTENANCE & REPAI RS	0	70 100				6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	0	72, 199 656	1			7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	545	1	70, 998		9.00
10. 00	01000 DI ETARY		3, 618	1	3, 618	2, 444	1
11. 00	01100 CAFETERI A		3,010		3,010	2, 444	11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	270	ō	270	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 645	1	1, 645	0	14.00
15.00	01500 PHARMACY	0	1, 143	0	1, 143	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 921	0	1, 921	0	16. 00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1, 550	1 0 111	1, 550		
30. 00	03000 ADULTS & PEDIATRICS	0	16, 553	2, 444	16, 553	2, 444	30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	Ιο	4 141	1 0	4 141	0	50.00
53.00	05300 ANESTHESI OLOGY			1	6, 164 0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C			_		0	54.00
57. 00	05700 CT SCAN		463	1		0	57.00
58. 00	05800 MRI	0	337		337	0	58.00
60.00	06000 LABORATORY	0	3, 605		3, 605	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	3, 387	1	3, 387	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	4, 389		4, 389	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	714	0	714	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00	03550 BEHAVI ORAL HEALTH	0	793	0	793	0	76.00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	4, 019	0	4, 019	0	88.00
88. 01	08801 RURAL HEALTH CLINIC		1	1	3, 624	0	88. 01
90.00	09000 CLINIC	0	2, 168	1	2, 168	0	90.00
90. 01	09001 SALEM MEDICAL CLINIC	0				0	90.01
91. 00	09100 EMERGENCY	0	4, 189		4, 189	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	3 /	0	65, 649	2, 444	64, 448	2, 444	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	ı		·		190.00
	19200 PHYSI CLANS PRI VATE OFFI CES	0	6, 550	0	6, 550	0	192.00
	19201 TEMPORALLY I DLE SPACE	0	0		0		192.01
	19202 STH FAM HLTH CRT 19203 RISE OUTREACH LAB	0	0		0		192. 02 192. 03
	07950 LITIGATION COSTS	0	0		0		194.00
	07951 MT VERNON SURGICAL CLINIC				0		194.00
200.00			٥		o o	O	200.00
201.00	, ,						201.00
202.00		0	2, 124, 361	230, 063	672, 435	1, 423, 163	1
	Part I)	_	_,,		3.2, .33	.,,	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	29. 423690	94. 133797	9. 471182	582. 308920	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	568, 074	23, 917	27, 332	135, 116	204.00
	Part II)						
205.00		0. 000000	7. 868170	9. 786007	0. 384969	55. 284779	205.00
201.00	NAUE adjustment amount to be all acated						20/ 22
206.00							206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						
	•	,			'		

	LOCATION - STATISTICAL BASIS	SALEM TOWNSHI	Provi der C	CN: 14-1345 P	eri od:	Worksheet B-1	
					rom 04/01/2022 o 03/31/2023	Date/Time Pre 8/29/2023 9:2	pared:
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
		(GROSS SALARI ES)	OF PERSONNEL (NUMBER	ADMI NI STRATI O	SERVICES & SUPPLY	(COSTED REQUIS.)	
		SALAWA ES)	HOUSED)	(NURSI NG	(COSTED	REGOT 5.)	
		11. 00	12. 00	SALARI ES)	REQUIS.)	15. 00	
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14. 00	15.00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	00592 ADMINISTRATIVE & GENERAL						5. 01
	00600 MAI NTENANCE & REPAI RS						6.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY						10.00
	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	0				11. 00 12. 00
13.00	01300 NURSING ADMINISTRATION	0	0	7, 784, 377			13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	0	,	0 440	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0			8, 648 6, 550	0, 046	1
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	19. 00
	03000 ADULTS & PEDIATRICS	0	0	2, 464, 620	122, 977	0	30.00
	ANCILLARY SERVICE COST CENTERS	_	_				
	05000 OPERATING ROOM 05300 ANESTHESIOLOGY	0	0	803, 204		0	50. 00 53. 00
	05400 RADI OLOGY-DI AGNOSTI C	Ö	0	Ö	99, 147	0	1
	05700 CT SCAN	0	0	0	,	0	
	05800 MRI 06000 LABORATORY	0		0	-,	0	58. 00 60. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	Ō	21, 889	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	8, 892	0	66. 00 67. 00
	06800 SPEECH PATHOLOGY	0	0		1, 638 0	0	68.00
	06900 ELECTROCARDI OLOGY	0	0	0	.,	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6, 324 448, 252	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	ő	Ö	Ö	0	8, 648	
	03550 BEHAVI ORAL HEALTH OUTPATI ENT SERVI CE COST CENTERS	0	0	199, 274	3, 634	0	76. 00
	08800 RURAL HEALTH CLINIC	0	O	1, 393, 256	24, 773	0	88. 00
	08801 RURAL HEALTH CLINIC II	0	0	1, 169, 906		0	
	09000 CLINIC 09001 SALEM MEDICAL CLINIC	0	0	239, 792	17, 451	0	
	09100 EMERGENCY	0	0	1, 514, 325	123, 062	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	0	7, 784, 377	1, 436, 076	8, 648	118.00
	NONREI MBURSABLE COST CENTERS	-					
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN 19200 PHYSICIANS PRIVATE OFFICES	0	0	0			190. 00 192. 00
	19201 TEMPORALLY IDLE SPACE	0	0	1	1		192.01
	19202 STH FAM HLTH CRT	0	0	0			192.02
	19203 RISE OUTREACH LAB 07950 LITIGATION COSTS	0		0	0		192. 03 194. 00
194. 01	07951 MT VERNON SURGICAL CLINIC	Ö	0	Ö	70		194. 01
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	0	O	41, 119	330, 288	2, 139, 385	
202 00	Part I)	0 000000	0 00000	0.005000	0.000440		
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 000000	0. 000000 0	0. 005282 6, 304		247. 384944 67. 769	203.00
201.00	Part II)			0,001	00,010		
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000810	0. 039363	7. 836378	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2)						207 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
					·		

Health Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1345 Period: Worksheet B-1

COST A	ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 14-1345	Peri od: From 04/01/2022	Worksheet B-	-1
					To 03/31/2023		
	Cost Center Description	MEDI CAL	SOCI AL	NONPHYSI CI AN	ı	8/29/2023 9:	20 am
	cost center bescription	RECORDS &	SERVI CE	ANESTHETI STS			
		LI BRARY	(PATI ENT	(ASSI GNED			
		(GROSS	DAYS)	TIME)			
		CHARGES)	47.00	10.00			
	CENEDAL CEDALCE COST CENTEDS	16. 00	17. 00	19. 00			
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT			I			1.00
2. 00	00200 CAP REL COSTS-BEDG & TTAT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00592 ADMINISTRATIVE & GENERAL						5. 01
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY						14.00
15.00	01500 PHARMACY	150 041 174					15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	150, 241, 174 0	0				16. 00 17. 00
17.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	1	0		19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	o _l		1	0		- 17.00
30. 00	03000 ADULTS & PEDI ATRI CS	12, 486, 971	0		0		30.00
00.00	ANCILLARY SERVICE COST CENTERS	12/ 100/ 77 1			<u> </u>		
50.00	05000 OPERATING ROOM	17, 224, 068	0		0		50.00
53.00	05300 ANESTHESI OLOGY	0	0		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 470, 744	0)	0		54.00
57.00	05700 CT SCAN	22, 818, 582	0)	0		57.00
58. 00	05800 MRI	3, 102, 994	0		0		58. 00
60.00	06000 LABORATORY	33, 265, 668	0	•	0		60.00
65.00	06500 RESPI RATORY THERAPY	4, 840, 009	0		0		65.00
66.00	06600 PHYSI CAL THERAPY	4, 436, 571	0	1	0		66.00
67.00	06700 OCCUPATI ONAL THERAPY	905, 455	0		0		67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	4, 782	0		0		68. 00 69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 436, 553 1, 242, 249	0		0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	788, 908	0		0		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 110, 955	0		0		73.00
76. 00	03550 BEHAVI ORAL HEALTH	872, 501	0	1	Ö		76.00
	OUTPATIENT SERVICE COST CENTERS	,		,	- 1		
88. 00	08800 RURAL HEALTH CLINIC	3, 357, 099	0		0		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 482, 594	0		0		88. 01
90.00	09000 CLI NI C	1, 096, 103	0		0		90.00
90. 01	09001 SALEM MEDICAL CLINIC	0	0)	0		90. 01
91.00	09100 EMERGENCY	22, 298, 368	0	1	0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS			1	_		٠
118.00	3 /	150, 241, 174	0		0		118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	ı	0		190.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	1	0		190.00
	19201 TEMPORALLY IDLE SPACE	0	0	1	0		192.00
	19201 TEMPORATET TOLE SPACE	0	0	1	0		192.01
	19203 RISE OUTREACH LAB	0	0	1	0		192. 02
	07950 LITIGATION COSTS	ő	n		0		194. 00
	07951 MT VERNON SURGICAL CLINIC	o	0		0		194. 01
200.00							200.00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B,	814, 841	0		0		202.00
	Part I)						
203.00		0. 005424	0. 000000	0. 00000	00		203.00
204.00	***	72, 972	0		0		204.00
	Part II)	2 222 424					
205.00		0. 000486	0. 000000	0. 00000	טט		205. 00
204 00	NAME adjustment amount to be allegated						204 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	1 1 2						207. 00
207.00	Parts III and IV)						207.00
		. '		•	•		

ealth Financial Systems	SALEM TOWNSH	LP HOSPITAL		In lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	From 04/01/2022 Part I To 03/31/2023 Date/Time 8/29/2023		Worksheet C Part I	pared:		
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	

					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)	0.00			5.00	
	LABORT FAIT DOUTENE OFFICE OF COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7 074 000	I	7 074 000			
30. 00	03000 ADULTS & PEDIATRICS	7, 271, 080		7, 271, 080	0	0	30.00
50.00	ANCILLARY SERVICE COST CENTERS	0.000.400		0 000 400			
50.00	05000 OPERATING ROOM	3, 209, 429		3, 209, 429	0	1	00.00
53.00	05300 ANESTHESI OLOGY	0 470 050		0 470 050	0	0	00.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 178, 353		2, 178, 353	0	0	0 11 00
57. 00	05700 CT SCAN	492, 689		492, 689	0	0	57.00
58.00	05800 MRI	109, 167		109, 167	0	0	58.00
60.00	06000 LABORATORY	3, 967, 522		3, 967, 522		0	60.00
65.00	06500 RESPIRATORY THERAPY	1, 073, 568		1, 073, 568		0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 119, 042		1, 119, 042		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	168, 592		168, 592		0	67.00
68.00	06800 SPEECH PATHOLOGY	2, 235		2, 235		0	68.00
	06900 ELECTROCARDI OLOGY	96, 879		96, 879		0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	607, 160		607, 160		0	1 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	651, 802		651, 802		0	
	07300 DRUGS CHARGED TO PATIENTS	2, 164, 379		2, 164, 379		0	73.00
76. 00	03550 BEHAVI ORAL HEALTH	542, 528		542, 528	0	0	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	2 222 0/7	I	2 222 0/7	0	0	00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	3, 222, 067		3, 222, 067	0		88. 00 88. 01
	09000 CLINIC	2, 307, 216		2, 307, 216	0		1
90. 00 90. 01	09000 CETNIC 09001 SALEM MEDICAL CLINIC	588, 024		588, 024	0	0	
		4 204 277		4 204 277	0	0	91.00
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	4, 384, 277		4, 384, 277	U		91.00
		1, 079, 262		1, 079, 262	0		
200.00		35, 235, 271		35, 235, 271	J		200.00
201.00		1, 079, 262		1, 079, 262			201.00
202.00	Total (see instructions)	34, 156, 009	0	34, 156, 009	0	1	202. 00

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1345	From 04/01/2022	Worksheet C Part I Date/Time Prepared: 8/29/2023 9: 20 am

				Ť	o 03/31/2023	Date/Time Pre 8/29/2023 9:2	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	TIENT ROUTINE SERVICE COST CENTERS				T		
	O ADULTS & PEDIATRICS	11, 160, 282		11, 160, 282			30.00
	LLARY SERVICE COST CENTERS	0.445.004	45 050 777	17.004.040			
	OO OPERATING ROOM	2, 165, 291	15, 058, 777			0.000000	
	OO ANESTHESI OLOGY	754 455	0	ľ	0.000000	0.000000	
	OO RADI OLOGY-DI AGNOSTI C	754, 455	11, 716, 289			0.000000	
	OO CT SCAN	1, 230, 372	21, 588, 210			0.000000	
58. 00 0580	DO LABORATORY	102, 960	3, 000, 034			0. 000000 0. 000000	
	ORESPIRATORY THERAPY	2, 832, 157	30, 433, 511				
		2, 674, 641	2, 165, 368			0.000000	
	OO PHYSI CAL THERAPY	554, 085	3, 882, 486			0.000000	
	OO OCCUPATI ONAL THERAPY	461, 666	443, 789			0.000000	1
	OO SPEECH PATHOLOGY	1, 682	3, 100			0.000000	
	DO ELECTROCARDI OLOGY	81, 018	2, 355, 535			0.000000	
	MEDICAL SUPPLIES CHARGED TO PATIENT	157, 141	1, 085, 108			0.000000	
	ON IMPL. DEV. CHARGED TO PATIENTS	201, 364	587, 544			0.000000	
	DO DRUGS CHARGED TO PATIENTS	597, 388	4, 513, 567			0.000000	
	O BEHAVI ORAL HEALTH	l U	872, 501	872, 501	0. 621808	0. 000000	76. 00
	PATIENT SERVICE COST CENTERS OF RURAL HEALTH CLINIC		2 257 000	2 257 000			88. 00
	1 RURAL HEALTH CLINIC II	0	3, 357, 099 1, 482, 594				88.00
90.00 0900		15 700	1, 482, 594			0. 000000	
	101 SALEM MEDICAL CLINIC	15, 709	1, 080, 394	1, 096, 103		0. 000000	
	OD EMERGENCY	0	22, 298, 368	22, 298, 368	0. 000000 0. 196619	0. 000000	
	O OBSERVATION BEDS (NON-DISTINCT PART	0				0. 000000	
200. 00		22 000 211	1, 326, 689			0.000000	
200.00	Subtotal (see instructions) Less Observation Beds	22, 990, 211	127, 250, 963	150, 241, 174			200. 00 201. 00
		22 000 211	127 250 042	150 241 174			
202. 00	Total (see instructions)	22, 990, 211	127, 250, 963	150, 241, 174	1 1		202.00

Health Financial Systems	HOSPI TAL	u of Form CMS-2	2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1345	Period: From 04/01/2022 To 03/31/2023	Worksheet C Part I Date/Time Pre 8/29/2023 9:2	pared: O am
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00

		litle XVIII	Hospi tai	COST
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57.00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MRI	0. 000000			58.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03550 BEHAVI ORAL HEALTH	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
88.01 08801 RURAL HEALTH CLINIC II				88. 01
90. 00 09000 CLI NI C	0. 000000			90.00
90.01 09001 SALEM MEDICAL CLINIC	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CMS-2	2552-10
	Provi der CO	Provi der CCN: 14-1345		Worksheet C Part I Date/Time Prep 8/29/2023 9:20	pared: 0 am
	Ti tl	e XIX	Hospi tal	Cost	
			Costs		
Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
1. 00	2. 00	3. 00	4. 00	5. 00	
	Total Cost (from Wkst. B, Part I, col. 26)	Titl Total Cost (from Wkst. B, Part I, col. 26)	Title XIX Total Cost (from Wkst. B, Part I, col. 26) Provider CCN: 14-1345 Title XIX Therapy Limit Total Costs	Provider CCN: 14-1345	Provider CCN: 14-1345

					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26) 1. 00	2, 00	3. 00	4. 00	5. 00	
	INDATIENT DOUTINE CEDVICE COCT CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 0	INPATIENT ROUTINE SERVICE COST CENTERS 0 03000 ADULTS & PEDIATRICS	7, 271, 080		7 271 000	0	0	30.00
30. 0	ANCI LLARY SERVI CE COST CENTERS	1,211,080		7, 271, 080		0	30.00
50.0		3, 209, 429		3, 209, 429		0	50.00
53. 0		3, 207, 427		3, 207, 427	0	0	53.00
54.0		2, 178, 353		2, 178, 353	0	0	54.00
57.0		492, 689		492, 689		0	57.00
58. 0		109, 167		109, 167		0	58.00
60.0		3, 967, 522		3, 967, 522		0	60.00
65.0		1, 073, 568		1, 073, 568		0	65.00
66.0	ł	1, 119, 042		1, 119, 042		0	66.00
67.0		168, 592		168, 592		0	67.00
68. 0	· ·	2, 235		2, 235		0	68.00
69. 0		96, 879		96, 879		0	69.00
71. 0		607, 160		607, 160		Ō	71.00
72.0		651, 802		651, 802		0	72.00
73.0		2, 164, 379		2, 164, 379		0	73.00
76.0	0 03550 BEHAVI ORAL HEALTH	542, 528		542, 528	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.0	O 08800 RURAL HEALTH CLINIC	3, 222, 067		3, 222, 067	0	0	88. 00
88.0	1 08801 RURAL HEALTH CLINIC II	2, 307, 216		2, 307, 216	0	0	88. 01
90.0	0 09000 CLI NI C	588, 024		588, 024	0	0	90.00
90.0	1 09001 SALEM MEDICAL CLINIC	0		0	0	0	90. 01
91.0		4, 384, 277		4, 384, 277	0	0	91.00
92.0	O 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 079, 262		1, 079, 262		0	92.00
200.	OO Subtotal (see instructions)	35, 235, 271	0	35, 235, 271	0		200. 00
201.		1, 079, 262		1, 079, 262			201.00
202.	00 Total (see instructions)	34, 156, 009	0	34, 156, 009	0	0	202. 00

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1345	Period: Worksheet C From 04/01/2022 Part I To 03/31/2023 Date/Time Prepared: 8/29/2023 9:20 am

					o 03/31/2023	Date/Time Pre 8/29/2023 9:2	
			Ti tl	e XIX	Hospi tal	Cost	
		Charges					
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1 1 0 000		1 11 1/0 000			
30. 00	03000 ADULTS & PEDIATRICS	11, 160, 282		11, 160, 282	!		30.00
50.00	ANCILLARY SERVICE COST CENTERS	0.4/5.004	45 050 777	17.004.046			
	05000 OPERATING ROOM	2, 165, 291	15, 058, 777			0. 000000	
53.00	05300 ANESTHESI OLOGY	754 455	0	1	0.000000	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	754, 455	11, 716, 289			0.000000	
57. 00	05700 CT SCAN	1, 230, 372	21, 588, 210			0.000000	
58.00	05800 MRI	102, 960	3, 000, 034			0.000000	1
60.00	06000 LABORATORY	2, 832, 157	30, 433, 511			0.000000	1
65.00	06500 RESPI RATORY THERAPY	2, 674, 641	2, 165, 368			0.000000	1
66.00	06600 PHYSI CAL THERAPY	554, 085	3, 882, 486			0.000000	1
67.00	06700 OCCUPATI ONAL THERAPY	461, 666	443, 789			0.000000	1
68. 00	06800 SPEECH PATHOLOGY	1, 682	3, 100			0.000000	
69. 00	06900 ELECTROCARDI OLOGY	81, 018	2, 355, 535			0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	157, 141	1, 085, 108			0.000000	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	201, 364	587, 544	•		0. 000000 0. 000000	
	07300 DRUGS CHARGED TO PATI ENTS 03550 BEHAVI ORAL HEALTH	597, 388	4, 513, 567				
76.00	OUTPATIENT SERVICE COST CENTERS	l d	872, 501	872, 501	0. 621808	0. 000000	76. 00
88. 00	08800 RURAL HEALTH CLINIC		2 257 000	2 257 000	0. 959777	0. 000000	88. 00
	08801 RURAL HEALTH CLINIC	0	3, 357, 099 1, 482, 594			0.000000	
	109000 CLINIC	15, 709	1, 482, 394			0. 000000	
	09001 SALEM MEDICAL CLINIC	15, 709	1,000,394		1	0. 000000	
	09100 EMERGENCY		22, 298, 368	1		0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1, 326, 689			0.000000	
200.00		22, 990, 211	1, 320, 669			0.000000	200.00
200.00	,	22, 770, 211	127, 230, 903	130, 241, 174			200.00
202.00		22, 990, 211	127, 250, 963	150, 241, 174			202.00

Heal th	Financial Systems	SALEM TOWNSHIE	P HOSPI TAL	In Lieu	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-1345	Peri od: From 04/01/2022 To 03/31/2023		pared: O am
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	05700 CT SCAN	0. 000000				57.00
	05800 MRI	0. 000000				58. 00
	06000 LABORATORY	0. 000000				60.00
	06500 RESPI RATORY THERAPY	0. 000000				65.00
	06600 PHYSI CAL THERAPY	0. 000000				66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
	06800 SPEECH PATHOLOGY	0. 000000				68. 00
	06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00

0.000000

0. 000000

0.000000

0.000000

0. 000000

0.000000

0.000000

0. 000000

73.00

76.00

88.00

88. 01

90.00

90. 01

91.00

92.00 200. 00

201. 00 202. 00

73.00 07300 DRUGS CHARGED TO PATIENTS

08801 RURAL HEALTH CLINIC II

88. 00 08800 RURAL HEALTH CLINIC

90. 01 09001 SALEM MEDICAL CLINIC

09100 EMERGENCY

76.00

88. 01

91.00

200.00

201.00

202.00

90. 00 |09000 | CLI NI C

03550 BEHAVI ORAL HEALTH
OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (see instructions)

Less Observation Beds

Subtotal (see instructions)

Health Financial Systems SA			SALEM TOWNSHIP HOSPITAL				In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL		_ COSTS				Peri od:		Worksheet D		
							To	04/01/2022 03/31/2023	Date/Time Pre 8/29/2023 9:2	pared: O am
					Titl∈	e XVIII		Hospi tal	Cost	
Cost	Center Description		Capi tal	Tot	al Charges	Ratio of Cos	st	I npati ent	Capital Costs	
			Related Cost	(f	rom Wkst.	to Charges		Program	(column 3 x	
			(from Wkst.	С	, Part I,	(col. 1 ÷		Charges	column 4)	
			B, Part II,		col. 8)	col . 2)				

						0/2//2020 /. 2	o am
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	265, 714	17, 224, 068	0. 015427	1, 181, 193	18, 222	50.00
53.00	05300 ANESTHESI OLOGY	0	0	0. 000000	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	212, 470	12, 470, 744	0. 017037	454, 624	7, 745	54.00
57.00	05700 CT SCAN	32, 869	22, 818, 582	0. 001440	703, 850	1, 014	57.00
58.00	05800 MRI	13, 857	3, 102, 994	0. 004466	49, 172	220	58. 00
60.00	06000 LABORATORY	186, 085	33, 265, 668	0. 005594	1, 597, 029	8, 934	60.00
65.00	06500 RESPI RATORY THERAPY	125, 337	4, 840, 009	0. 025896	1, 563, 152	40, 479	65.00
66.00	06600 PHYSI CAL THERAPY	156, 161	4, 436, 571	0. 035199	123, 151	4, 335	66.00
67.00	06700 OCCUPATI ONAL THERAPY	25, 287	905, 455	0. 027927	89, 413	2, 497	67.00
68.00	06800 SPEECH PATHOLOGY	35	4, 782	0. 007319	903	7	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 528	2, 436, 553	0. 001038	45, 372	47	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 686	1, 242, 249	0. 007797	86, 705	676	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	26, 059	788, 908	0. 033032	122, 772	4, 055	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	70, 253	5, 110, 955	0. 013746	310, 098	4, 263	73.00
76.00	03550 BEHAVI ORAL HEALTH	33, 755	872, 501	0. 038688	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	178, 653	3, 357, 099	0. 053216	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	151, 594	1, 482, 594	0. 102249	0	0	88. 01
90.00	09000 CLI NI C	78, 189	1, 096, 103	0. 071334	10, 428	744	90.00
90. 01	09001 SALEM MEDICAL CLINIC	0	0	0.000000	0	0	90. 01
91.00	09100 EMERGENCY	212, 602	22, 298, 368	0. 009534	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	115, 076	1, 326, 689	0. 086739	0	0	92.00
200.00	Total (lines 50 through 199)	1, 896, 210	139, 080, 892		6, 337, 862	93, 238	200.00
		•		. '			•

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1345	Peri od: Worksheet D
THROUGH COSTS		From 04/01/2022 Part IV

				-	Го 03/31/2023	Date/Time Pre 8/29/2023 9:2	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments	0.00		2.22	
	ANCILLARY SERVICE COST CENTERS	1. 00	2A	2.00	3A	3. 00	
FO 00	05000 OPERATING ROOM	1		ı ,			F0 00
	05300 ANESTHESI OLOGY	0	0			0	50.00 53.00
	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0			0	
	05700 CT SCAN	0	0			0	54.00 57.00
	05800 MRI	0	0			0	58.00
	06000 LABORATORY		0			0	60.00
	06500 RESPIRATORY THERAPY	0	0			0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0			0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY					0	67.00
	06800 SPEECH PATHOLOGY					0	68.00
	06900 ELECTROCARDI OLOGY	0				o o	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			o o	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0			o o	73.00
	03550 BEHAVI ORAL HEALTH	0	0		0	0	76.00
	OUTPATIENT SERVICE COST CENTERS	-	-		-		1
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 SALEM MEDICAL CLINIC	0	0		0	0	90. 01
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00	Total (lines 50 through 199)	0	0	(0	0	200.00

Не	alth Financial Syst	ems		SAL	EM TOWNSH	HIP H	IOSPI TAL		In Lie	u of Form CMS-2552-10
	PPORTIONMENT OF INPA HROUGH COSTS	ATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER PA	ASS	Provi der	CCN: 14-1345	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D Part IV Date/Time Prepared:

			Т	o 03/31/2023	Date/Time Pre	
		Title	XVIII	Hospi tal	Cost	o am
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
· ·	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	0	17, 224, 068	1	
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	0	12, 470, 744	1	
57. 00 05700 CT SCAN	0	0	0	22, 818, 582		
58. 00 05800 MRI	0	0	0	3, 102, 994	1	
60. 00 06000 LABORATORY	0	0	0	33, 265, 668	1	
65. 00 06500 RESPI RATORY THERAPY	0	0	0	4, 840, 009	1	
66. 00 06600 PHYSI CAL THERAPY	0	0	0	4, 436, 571	1	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	905, 455		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	4, 782		
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	2, 436, 553		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1, 242, 249		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	788, 908		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	5, 110, 955		
76. 00 03550 BEHAVI ORAL HEALTH	0	0	0	872, 501	0.000000	76. 00
OUTPATIENT SERVICE COST CENTERS	T _	T	1 -	T		
88.00 08800 RURAL HEALTH CLINIC	0	0	0	3, 357, 099		
88. 01 08801 RURAL HEALTH CLINIC II	0	0	0	1, 482, 594	1	88. 01
90. 00 09000 CLI NI C	0	0	0	1, 096, 103		
90. 01 09001 SALEM MEDICAL CLINIC	0	0	0	0	0. 000000	
91. 00 09100 EMERGENCY	0	0	0	22, 298, 368	1	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1, 326, 689		
200.00 Total (lines 50 through 199)	0) 0	1 0	139, 080, 892		200. 00

Health Financial Systems	SALEM TOWNSHII	P HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A THROUGH COSTS	NCILLARY SERVICE OTHER PASS	Provider Co		Peri od: From 04/01/2022	Worksheet D Part IV	
				To 03/31/2023	Date/Time Pre 8/29/2023 9:2	pared: O am
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11.00	12.00	13.00	

			II LIE	XVIII	ноѕрі таі	COST	
Cost	t Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	SERVI CE COST CENTERS						
	RATING ROOM	0. 000000	1, 181, 193	0	0	0	
	STHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI	OLOGY-DI AGNOSTI C	0. 000000	454, 624	0	0	0	54.00
57.00 05700 CT S	SCAN	0. 000000	703, 850	0	0	0	57.00
58.00 05800 MRI		0. 000000	49, 172		0	0	58. 00
60. 00 06000 LABO	DRATORY	0. 000000	1, 597, 029	0	0	0	60.00
65. 00 06500 RESP	PI RATORY THERAPY	0. 000000	1, 563, 152	0	0	0	65.00
66. 00 06600 PHYS	SI CAL THERAPY	0. 000000	123, 151	0	0	0	66.00
	JPATI ONAL THERAPY	0. 000000	89, 413		0	0	67.00
68. 00 06800 SPEE	ECH PATHOLOGY	0. 000000	903	0	0	0	68. 00
69.00 06900 ELEC	CTROCARDI OLOGY	0. 000000	45, 372	0	0	0	69. 00
71. 00 07100 MEDI	CAL SUPPLIES CHARGED TO PATIENT	0. 000000	86, 705	0	0	0	71.00
72.00 07200 I MPL	L. DEV. CHARGED TO PATIENTS	0. 000000	122, 772	0	0	0	72.00
73.00 07300 DRUG	GS CHARGED TO PATLENTS	0. 000000	310, 098	0	0	0	73.00
76. 00 03550 BEHA	AVI ORAL HEALTH	0. 000000	0	0	0	0	76.00
OUTPATI ENT	T SERVICE COST CENTERS						
88. 00 08800 RURA	AL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88. 01 08801 RURA	AL HEALTH CLINIC II	0. 000000	0	0	0	0	88. 01
90. 00 09000 CLIN	NI C	0. 000000	10, 428	0	0	0	90.00
90. 01 09001 SALE	EM MEDICAL CLINIC	0. 000000	0	0	0	0	90. 01
91.00 09100 EMER	RGENCY	0. 000000	0	0	0	0	91.00
92. 00 09200 OBSE	ERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
200. 00 Tota	al (lines 50 through 199)		6, 337, 862	0	0	0	200.00
•		•		·			

Health Financial Systems	SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 04/01/2022 Fo 03/31/2023		
		Title	: XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 186334	0	5, 960, 48	3 0	0	00.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 174677	0	4, 257, 61	6 0	0	
57.00 05700 CT SCAN	0. 021592	0	8, 522, 38	5 0	0	
58. 00 05800 MRI	0. 035181	0	1, 013, 23		0	
60. 00 06000 LABORATORY	0. 119268	0	10, 110, 96	9 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 221811	0	923, 51	7 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 252231	0	1, 387, 24	1 0	0	00.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 186196	0	120, 94	9 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 467378	0	2, 38	6 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 039761	0	925, 44	2 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 488759	0	425, 14	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 826208	0	241, 68	2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 423478	0	2, 610, 19	552	0	73.00
76. 00 03550 BEHAVI ORAL HEALTH	0. 621808	0	681, 92	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88. 00
88.01 08801 RURAL HEALTH CLINIC II						88. 01
90. 00 09000 CLI NI C	0. 536468	0	359, 31	1 189	0	90.00
90.01 09001 SALEM MEDICAL CLINIC	0. 000000	0	(0	0	90. 01
91. 00 09100 EMERGENCY	0. 196619	0	6, 194, 94	5 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 813500	0	360, 67	3 0	0	92.00
200.00 Subtotal (see instructions)		0	44, 098, 09	741	0	200.00
201.00 Less PBP Clinic Lab. Services-Program			[0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	44, 098, 09	4 741	0	202. 00

Health Financial Systems	SALEM TOWNSHIP	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1345	From 04/01/2022	Worksheet D Part V Date / Time Propagate

					From 04/01/2022 To 03/31/2023	Part V Date/Time Pre 8/29/2023 9:2	
			Title	XVIII	Hospi tal	Cost	
		Cos					
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
	ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				_
50. 00	05000 OPERATING ROOM	1, 110, 642	0	1			50.00
	05300 ANESTHESI OLOGY	1, 110, 042	0	1			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	743, 708	0				54.00
57. 00	05700 CT SCAN	184, 015	0				57.00
58. 00	05800 MRI	35, 647	0				58.00
60. 00	06000 LABORATORY	1, 205, 915	0				60.00
	06500 RESPI RATORY THERAPY	204, 846					65.00
	06600 PHYSI CAL THERAPY	349, 905					66.00
67. 00	06700 OCCUPATI ONAL THERAPY	22, 520					67.00
68. 00	06800 SPEECH PATHOLOGY	1, 115	0				68.00
69.00	06900 ELECTROCARDI OLOGY	36, 796	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	207, 791	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	199, 680	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 105, 361	234				73.00
76.00	03550 BEHAVI ORAL HEALTH	424, 023	0				76. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC						88. 00
	08801 RURAL HEALTH CLINIC II						88. 01
	09000 CLI NI C	192, 759	101	1			90.00
	09001 SALEM MEDICAL CLINIC	0	0	•			90. 01
	09100 EMERGENCY	1, 218, 044	0	•			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	293, 407	0	1			92.00
200.00		7, 536, 174	335	'			200.00
201. 00		0					201. 00
202. 00	Only Charges Net Charges (line 200 - line 201)	7, 536, 174	335				202.00
202.00	met onarges (Trie 200 - Trie 201)	1, 330, 174	1 333	1			1202.00

Health Financial Systems	SALEM TOWNSHI	P HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 04/01/2022 To 03/31/2023	Worksheet D Part I Date/Time Pre 8/29/2023 9:2	pared: 0 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal Rel ated Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 /	
	(from Wkst. B, Part II, col. 26)		Related Cost (col. 1 - col. 2)		col . 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	775, 276	198, 006	577, 27	0 2, 137	270. 13	30.00
200.00 Total (lines 30 through 199)	775, 276		577, 27	0 2, 137		200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x				
		col . 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2	540				30.00
200.00 Total (lines 30 through 199)	2	540				200.00

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLA	Y SERVICE CAPITAL COSTS Provider CCN: 14-1	345 Peri od: Worksheet D Part II To 03/31/2023 Date/Time Prepared: 8/29/2023 9: 20 am

					From 04/01/2022 Fo 03/31/2023	Date/Time Pre	
			T' 11		11	8/29/2023 9: 2	0 am
	0 1 0 1 0			e XI X	Hospi tal	Cost	
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col . 26) 1.00	2.00	3.00	4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5.00	
	05000 OPERATING ROOM	2/5 71/	17 224 040	0.01540	7 0	0	50.00
	05000 OPERATING ROOM 05300 ANESTHESI OLOGY	265, 714	17, 224, 068			0	53.00
		0	10 470 744	0.000000		0	54.00
	05400 RADI OLOGY-DI AGNOSTI C	212, 470	12, 470, 744			0	
	05700 CT SCAN	32, 869	22, 818, 582			0	57.00
	05800 MRI	13, 857	3, 102, 994			0	58.00
	06000 LABORATORY	186, 085	33, 265, 668			0	60.00
	06500 RESPI RATORY THERAPY	125, 337	4, 840, 009			0	65.00
	06600 PHYSI CAL THERAPY	156, 161	4, 436, 571			0	66.00
	06700 OCCUPATI ONAL THERAPY	25, 287	905, 455			0	67.00
	06800 SPEECH PATHOLOGY	35	4, 782			0	68. 00
	06900 ELECTROCARDI OLOGY	2, 528	2, 436, 553			0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 686	1, 242, 249			0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	26, 059	788, 908			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	70, 253	5, 110, 955	0. 013746	6 0	0	73.00
	03550 BEHAVI ORAL HEALTH	33, 755	872, 501	0. 038688	3 0	0	76. 00
	OUTPAȚI ENT SERVI CE COST CENTERS						
	08800 RURAL HEALTH CLINIC	178, 653	3, 357, 099			0	
88. 01	08801 RURAL HEALTH CLINIC II	151, 594	1, 482, 594	0. 102249	9 0	0	88. 01
90.00	09000 CLI NI C	78, 189	1, 096, 103	0. 071334	4 0	0	90.00
90. 01	09001 SALEM MEDICAL CLINIC	0	0	0. 000000	0	0	90. 01
91. 00	09100 EMERGENCY	212, 602	22, 298, 368	0. 009534	4 0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	115, 076	1, 326, 689	0. 086739	9 0	0	92.00
200. 00	Total (lines 50 through 199)	1, 896, 210	139, 080, 892		0	0	200. 00

Health Financial Systems	SALEM TOWNSHI	P HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 04/01/2022 To 03/31/2023		epared: 20 am
			e XIX	Hospi tal	Cost	
Cost Center Description	Nursing Program Post-Stepdown	Nursi ng Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education	
	Adjustments	4 00	0.4	0.00	Cost	
INDATIONE DOUTING CODYLOG COCT CONTEDC	1A	1. 00	2A	2. 00	3. 00	
30.00 O3000 ADULTS & PEDIATRICS	0	0		0 0	0	00.00
200.00 Total (lines 30 through 199)	0	0	T	0 0		200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDLATRICS 200.00 Total (lines 30 through 199)	0	0	2, 13 2, 13			30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems	SALEM TOWNSHIP I	HOSPI TAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1345		Worksheet D
THROUGH COSTS			From 04/01/2022	

	66616				To 03/31/2023	8/29/2023 9: 2	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician		Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	ANOUGH ARV CERVILOE COCT CENTERS	1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATI NG ROOM	0	0)	0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0)	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
57.00	05700 CT SCAN	0	0)	0	0	57.00
58.00	05800 MRI	0	0	<u>'</u>	0	0	58.00
60.00	06000 LABORATORY	0	0	<u>'</u>	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	<u>'</u>	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	<u>'</u>	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	<u>'</u>	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	<u>'</u>	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	<u>'</u>	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	<u>'</u>	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	<u>'</u>	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		<u>'</u>	0	0	73.00
76. 00	03550 BEHAVI ORAL HEALTH OUTPATI ENT SERVI CE COST CENTERS] 0	0	1	0 0	0	76. 00
88. 00	08800 RURAL HEALTH CLINIC	1 0	1	<u>, </u>			88. 00
88. 00	08801 RURAL HEALTH CLINIC	0	0		0	0	88.00
90.00	109000 CLINIC				0	0	90.00
90.00	09001 SALEM MEDICAL CLINIC				0	0	90.00
90.01	1091001 SALEM MEDICAL CLINIC				0	0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			Ί	0	0	92.00
200.00	,				0	0	200.00
200.00		1	1	1	o _l 0	١ ٠	1200.00

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 14-1345	Peri od: Worksheet D
THROUGH COSTS		From 04/01/2022 Part IV

THROUGH	COSTS				To 03/31/2023		
				e XIX	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
			5.00		7.00	instructions)	
	NOLLI ADV. OFDIN OF COOT OFFITEDS	4. 00	5. 00	6. 00	7. 00	8. 00	
	NCILLARY SERVICE COST CENTERS				17 224 0/0	0.000000	FO 00
	05000 OPERATING ROOM	0	0		17, 224, 068		1
	05300 ANESTHESI OLOGY	0	0		0	0. 000000	•
	05400 RADI OLOGY-DI AGNOSTI C	0	0	9	12, 470, 744	0.000000	
	05700 CT SCAN	0	0	9	22, 818, 582		
	05800 MRI	0	0	(3, 102, 994		
	06000 LABORATORY	0	0	9	33, 265, 668		
	06500 RESPIRATORY THERAPY	0	0	9	4, 840, 009		
	06600 PHYSI CAL THERAPY	0	0	9	4, 436, 571		
	06700 OCCUPATI ONAL THERAPY	0	0	(905, 455		1
	06800 SPEECH PATHOLOGY	0	0	(4, 782		68.00
	06900 ELECTROCARDI OLOGY	0	0	(2, 436, 553		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(1, 242, 249		
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(788, 908		1
	07300 DRUGS CHARGED TO PATIENTS	0	0	(5, 110, 955		1
	03550 BEHAVI ORAL HEALTH	0	0	(872, 501	0.000000	76. 00
	DUTPATIENT SERVICE COST CENTERS	T	T .	T	T		
	08800 RURAL HEALTH CLINIC	0	0	(3, 357, 099		
	08801 RURAL HEALTH CLINIC II	0	0	(1, 482, 594		
	09000 CLI NI C	0	0	(1, 096, 103		1
	09001 SALEM MEDICAL CLINIC	0	0	(0	0. 000000	
	09100 EMERGENCY	0	0	(22, 298, 368		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1	.,,		1
200. 00	Total (lines 50 through 199)	0	0	(139, 080, 892		200. 00

Health Financial Systems	Systems SALEM TOWNSHIP HOSPITAL				u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN THROUGH COSTS	NCILLARY SERVICE OTHER PASS	Provider Co	CN: 14-1345	Peri od: From 04/01/2022 To 03/31/2023		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷	, and the second	Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	

		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	0	0	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0	0	0	0	54.00
57.00 05700 CT SCAN	0. 000000	0	0	0	0	57.00
58. 00 05800 MRI	0. 000000	0	0	0	0	58. 00
60. 00 06000 LABORATORY	0. 000000	0	0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0	0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0	0	0	0	73.00
76. 00 03550 BEHAVI ORAL HEALTH	0. 000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0	0	0	0	88. 01
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90.01 09001 SALEM MEDICAL CLINIC	0. 000000	0	0	0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
200.00 Total (lines 50 through 199)		0	0	0	0	200.00
, , ,	. '		. '		•	•

Health Financial Systems SALEM TOWNSH	SALEM TOWNSHIP HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1345	Peri od: From 04/01/2022	Worksheet D-1				
		To 03/31/2023	Date/Time Pre 8/29/2023 9:2				
	Title XVIII	Hospi tal	Cost				

		Title XVIII	Hospi tal	8/29/2023 9: 2 Cost	0 am
	Cost Center Description	THE AVIII	1103pi tai	0031	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	excluding newborn)		2, 870	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			2, 137	2. 00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3.00
4 00	do not complete this line.	- d - d \		1 711	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	1, 711 557	4. 00 5. 00
0.00	reporting period	om days) im oagn becomb	51 01 01 the cost	007	0.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	176	6.00
7 00	reporting period (if calendar year, enter 0 on this line)	and the second s	04 . 6 . 11		7 00
7. 00	Total swing-bed NF type inpatient days (including private rool reporting period	m days) through December	31 OF the COST	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	1, 053	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private m	room days)	435	10. 00
10.00	through December 31 of the cost reporting period (see instruc	tions)	com days)	100	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private m	room days) after	146	11. 00
12 00	December 31 of the cost reporting period (if calendar year, e		to room dovo)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including prival	te room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14. 00 15. 00	Medically necessary private room days applicable to the Prograte Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period	ditter becomber of or	1110 0031		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	120. 63	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	120. 63	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting ported (line	7, 271, 080 9 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost report	ing period (ine	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00
24.00	x line 18)	. 21 -6		0	24.00
24. 00	Swing-bed cost applicable to NF type services through Decembe $7 \times 1 = 19$	er 31 of the cost reporti	ng period (Tine	U	24. 00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.00
26. 00	x line 20) Total swing-bed cost (see instructions)			1, 857, 041	26. 00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 414, 039	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
29. 00 30. 00	Pri vate room charges (excluding swing-bed charges)			0	29. 00 30. 00
31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	rtions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li			0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37. 00
200	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				00 -
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 533. 48	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		2, 667, 754 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			2, 667, 754	
		,			,

ealth Financial Systems	SALEM TOWNSHI				u of Form CMS-2	
OMPUTATION OF INPATIENT OPERATING COST		Provi der (CCN: 14-1345	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Pre 8/29/2023 9:2	epare
Cost Center Description	Total Inpatient Cost	Title Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Cost Program Cost (col. 3 x col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
2.00 NURSERY (title V & XIX only)						42.
Intensive Care Type Inpatient Hospital Un 3.00 INTENSIVE CARE UNIT	Its		T			43.
4.00 CORONARY CARE UNIT						44.
5. 00 BURN INTENSIVE CARE UNIT						45.
5.00 SURGICAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY)						46. 47.
Cost Center Description						47.
2 00 D	(WILL D.O I. C	2 11 200			1.00	10
3.00 Program inpatient ancillary service cost 3.01 Program inpatient cellular therapy acquis			· III line 10) column 1)	1, 184, 297 0	1
9.00 Total Program inpatient costs (sum of lin				o, cordillir i)	3, 852, 051	
PASS THROUGH COST ADJUSTMENTS	Ŭ	,	,			
0.00 Pass through costs applicable to Program	inpatient routine	services (fro	om Wkst. D, su	um of Parts I and	0	50.
	inpatient ancillar	rv services (f	rom Wkst. D.	sum of Parts II	0	51
and IV)		, (.			_	
2.00 Total Program excludable cost (sum of lin				hard at a said	0	1
3.00 Total Program inpatient operating cost ex medical education costs (line 49 minus li		elated, non-pr	nysician anest	thetist, and	0	53
TARGET AMOUNT AND LIMIT COMPUTATION	110 02)					1
4.00 Program discharges						54
5.00 Target amount per discharge 5.01 Permanent adjustment amount per discharge					0. 00 0. 00	
5.02 Adjustment amount per discharge (contract					0.00	
5.00 Target amount (line 54 x sum of lines 55,	55. 01, and 55. 02)				0	56
7.00 Difference between adjusted inpatient ope	rating cost and ta	arget amount ((line 56 minus	s line 53)	0	1
3.00 Bonus payment (see instructions) 7.00 Trended costs (lesser of line 53 ÷ line 5	4 or line 55 from	n the cost ren	ortina period	d ending 1996	0 0. 00	
updated and compounded by the market bask			or tring period	a charring 1770,	0.00	"
0.00 Expected costs (lesser of line 53 ÷ line	54, or line 55 fro	om prior year	cost report,	updated by the	0. 00	60
market basket) 1.00 Continuous improvement bonus payment (if 55.01, or line 59, or line 60, enter the 53) are less than expected costs (lines 5	lesser of 50% of t	the amount by	which operati	ng costs (line	0	61
enter zero. (see instructions)		· ·		•		
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive p	avment (see instri	ictions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST	ayment (see mistro	icti ons)			0	1 03
1.00 Medicare swing-bed SNF inpatient routine	costs through Dece	ember 31 of th	ne cost report	ing period (See	1, 102, 064	64
instructions)(title XVIII only) 5.00 Medicare swing-bed SNF inpatient routine	costs ofter Decemb	or 21 of the	cost roportin	na pariod (Saa	369, 888	45
5.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after beceilik	bei 31 01 the	cost reportir	ig perrou (see	307, 000	03
6.00 Total Medicare swing-bed SNF inpatient ro	utine costs (line	64 plus line	65)(title XVI	<pre>II only); for</pre>	1, 471, 952	66
CAH, see instructions 7.00 Title V or XIX swing-bed NF inpatient rou	tino costs through	Docombon 21	of the cost r	conorting poriod	0	67
(line 12 x line 19)	time costs timougi	i beceiibei 31	of the cost i	epoi triig perrou	0	07
3.00 Title V or XIX swing-bed NF inpatient rou	tine costs after [December 31 of	the cost rep	oorting period	0	68
(line 13 x line 20) 2.00 Total title V or XIX swing-bed NF inpatie	nt routing costs /	(lino 67 : lir	20, 69)		0	69
PART III - SKILLED NURSING FACILITY, OTHER					0	09
0.00 Skilled nursing facility/other nursing fa				7)		70
I.00 Adjusted general inpatient routine servic		ine 70 ÷ line	2)			71
2.00 Program routine service cost (line 9 x li 3.00 Medically necessary private room cost app		n (line 14 x l	ine 35)			72
1.00 Total Program general inpatient routine's	ervice costs (l̃ine	e 72 + line 73	3)			74
5.00 Capital-related cost allocated to inpatie	nt routine service	e costs (from	Worksheet B,	Part II, column		75
26, line 45) 26, line 45, 26, line 45,	line 2)					76
7.00 Program capital related costs (line 9 x l						77
.00 Inpatient routine service cost (line 74 m		amoud deservice	ado)			78
2.00 Aggregate charges to beneficiaries for ex 2.00 Total Program routine service costs for c				nus line 701		79 80
.00 Inpatient routine service costs for C	•	ost rimitati	(11116 /6 IIII	1103 11116 /7)		81
2.00 Inpatient routine service cost limitation	(line 9 x line 8	*				82
8.00 Reasonable inpatient routine service cost		ns)				83
4.00 Program inpatient ancillary services (see 5.00 Utilization review - physician compensati		ons)				84
6.00 Total Program inpatient operating costs (sum of lines 83 th					86.
PART IV - COMPUTATION OF OBSERVATION BED					467	
7.00 Total observation bed days (see instructi					426	87

Health Financial Systems	SALEM TOWNSHI	P HOSPI TAL		In Lie	u of Form CMS-2	2552-10
		Peri od:	Worksheet D-1			
				From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9:20	pared: 0 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			1, 079, 262	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	775, 276	7, 271, 080	0. 10662	25 1, 079, 262	115, 076	90.00
91.00 Nursing Program cost	O	7, 271, 080	0. 00000	00 1, 079, 262	0	91.00
92.00 Allied health cost	0	7, 271, 080	0. 00000	00 1, 079, 262	0	92.00
93.00 All other Medical Education	0	7, 271, 080	0. 00000	1, 079, 262	0	93.00

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1345	Peri od: From 04/01/2022	Worksheet D-1		
			Date/Time Pre 8/29/2023 9:2		
	Title XIX	Hospi tal	Cost		

-		Title XIX	Hospi tal	8/29/2023 9: 2 Cost	U alli	
	Cost Center Description	THE ALK	nospi tui	0031		
	PART I - ALL PROVIDER COMPONENTS					
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) 2,870					
2.00	Inpatient days (including private room days, excluding swing- Inpatient days (including private room days, excluding swing-	,		2, 870 2, 137	1. 00 2. 00	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,					
0.00	do not complete this line.					
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		1, 711	4.00	
5.00	Total swing-bed SNF type inpatient days (including private ro	0	5.00			
	reporting period				6. 00	
6. 00						
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost				7.00	
7.00	reporting period					
8.00					8.00	
	reporting period (if calendar year, enter 0 on this line)					
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	2	9. 00	
10. 00	newborn days) (see instructions)					
10.00	00 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)					
11. 00						
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	•			
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00	
40.00	through December 31 of the cost reporting period	V and Charle Parameters			40.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00	
14. 00	Medically necessary private room days applicable to the Progr			0	14.00	
15. 00	Total nursery days (title V or XIX only)	am (exertaining swring bea	udy3)	Ö	15.00	
16.00	Nursery days (title V or XIX only)			0	16.00	
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost		17. 00	
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	os after December 21 of	the cost		18. 00	
10.00	reporting period	es al tel becember 51 01	the cost		10.00	
19. 00	Medicald rate for swing-bed NF services applicable to service	s through December 31 of	the cost	180. 00	19.00	
	reporting period	-				
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	180. 00	20.00	
21. 00	reporting period 00 Total general inpatient routine service cost (see instructions)				21.00	
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	7, 271, 080 9 0	22.00	
	5 x line 17)					
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00	
0.4.00	x line 18)	24 . 6 . 1		1 110	04.00	
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporti	ng period (iine	1, 440	24.00	
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	-1, 440	25. 00	
	x line 20)	,				
26. 00	, ,			1, 857, 041	•	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 414, 039	27. 00	
28 00	General inpatient routine service charges (excluding swing-be	d and observation hed ch	arnes)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed er	iai ges)	Ö	29.00	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	1	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 22)(see instrus	etions)	0.00		
34. 00 35. 00	Average per diem private room cost differential (line 34 x li		iti ulis <i>)</i>	0. 00 0. 00		
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37.00	
	27 minus line 36)	·	·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			2, 533. 48	38.00	
39.00	Program general inpatient routine service cost per diem (see	•		2, 533. 48 5, 067	39.00	
40. 00	Medically necessary private room cost applicable to the Progr	•		0	40.00	
	.00 Total Program general inpatient routine service cost (line 39 + line 40) 5,067					
			'			

Heal th Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu of Form C COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 14-1345 Period: From 04/01/2022 To 03/31/2023 Date/Time 8/29/2023 Title XIX Hospital Cost Center Description Total Total Average Per Program Days Program Co	D-1 Prepared: 9: 20 am
Title XIX Hospital Co.	st st
	st
Inpatient Inpatient Diem (col. 1 (col. 3 : cost Days ÷ col. 2) col. 4)	
1.00 2.00 3.00 4.00 5.00	40.00
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	42. 00
43.00 INTENSIVE CARE UNIT	43.00
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT	44. 00 45. 00
46.00 SURGICAL INTENSIVE CARE UNIT	46. 00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description	47.00
1.00	0 40 00
	0 48.00 0 48.01 067 49.00
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	0 50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0 51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)	0 52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION	5.4.00
54.00 Program discharges 55.00 Target amount per discharge 0	0 54.00
55.01 Permanent adjustment amount per discharge 0	. 00 55. 01
55.02 Adjustment amount per discharge (contractor use only) 56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0 55.02
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0 57.00
58.00 Bonus payment (see instructions) 59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,	0 58.00
updated and compounded by the market basket)	
60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus	0 61.00
55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	
62.00 Relief payment (see instructions)	0 62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST	0 63.00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0 64.00
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See	0 65.00
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for	0 66.00
CAH, see instructions	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0 67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0 69.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71)	71. 00 72. 00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	74. 00 75. 00
76.00 Per diem capital-related costs (line 75 ÷ line 2)	76.00
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77)	77. 00 78. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	79. 00 80. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation	80.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)	82.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions)	83. 00 84. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	85. 00 86. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	
	426 87.00 .48 88.00

Health Financial Systems	SALEM TOWNSHI	P HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9:2	pared: 0 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			1, 079, 262	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
				,	instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	775, 276	7, 271, 080	0. 10662	25 1, 079, 262	115, 076	90.00
91.00 Nursing Program cost	0	7, 271, 080	0. 00000	00 1, 079, 262	0	91.00
92.00 Allied health cost	0	7, 271, 080	0. 00000	00 1, 079, 262	0	92.00
93.00 All other Medical Education	0	7, 271, 080	0. 00000	00 1, 079, 262	0	93.00

Health Financial Systems	SALEM TOWNSHIP HOSPITAL		Inlie	u of Form CMS-2	2552_10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od: From 04/01/2022 To 03/31/2023	Worksheet D-3	pared:
-	Title	XVIII	Hospi tal	Cost	.o am
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			4, 685, 226		30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 18633			
53. 00 05300 ANESTHESI OLOGY		0. 00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17467		79, 412	1
57. 00 05700 CT SCAN		0. 02159			
58. 00 05800 MRI		0. 03518			
60. 00 06000 LABORATORY		0. 11926		· ·	1
65. 00 06500 RESPI RATORY THERAPY		0. 22181			1
66. 00 06600 PHYSI CAL THERAPY		0. 25223		31, 062	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 18619		16, 648	
68. 00 06800 SPEECH PATHOLOGY		0. 46737			
69. 00 06900 ELECTROCARDI OLOGY		0. 03976			1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	П	0. 48875		· ·	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 82620		101, 435	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 42347			1
76. 00 03550 BEHAVI ORAL HEALTH		0. 62180	0 8	0	76. 00
OUTPATIENT SERVICE COST CENTERS		1		_	
88. 00 08800 RURAL HEALTH CLINIC		0. 00000		0	
88. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	
90. 00 09000 CLI NI C		0. 53646		5, 594	
90. 01 09001 SALEM MEDICAL CLINIC		0.00000		0	
91. 00 09100 EMERGENCY	_	0. 19661		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR		0. 81350		0	
200.00 Total (sum of lines 50 through 94			6, 337, 862	1, 184, 297	
201.00 Less PBP Clinic Laboratory Service			0		201.00
202.00 Net charges (line 200 minus line 2	(01)	l	6, 337, 862		202. 00

Health Financial Systems	SALEM TOWNSHIP HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN:		Peri od:	Worksheet D-3	
	Component CCI		From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9:2	pared: O am
	Ti tle X		wing Beds - SNF	Cost	
Cost Center Description	Ra	atio of Cost	I npati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 186334		0	50.00
53. 00 05300 ANESTHESI OLOGY		0.000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17467	14, 889	2, 601	54.00
57.00 05700 CT SCAN		0. 021592	59, 285	1, 280	57.00
58. 00 05800 MRI		0. 03518	12, 695	447	58. 00
60. 00 06000 LABORATORY		0. 119268	239, 797	28, 600	60.00
65. 00 06500 RESPIRATORY THERAPY		0. 22181	259, 274	57, 510	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 252231	287, 262	72, 456	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 186196	249, 500	46, 456	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 467378	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 03976	8, 604	342	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 488759	400	196	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 826208	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 423478	82, 956	35, 130	73.00
76. 00 03550 BEHAVI ORAL HEALTH		0. 621808	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	·				
88. 00 08800 RURAL HEALTH CLINIC		0.000000		0	88. 00
88.01 08801 RURAL HEALTH CLINIC II		0. 000000		0	88. 01
90. 00 09000 CLI NI C		0. 536468	748	401	90.00
90. 01 09001 SALEM MEDICAL CLINIC		0. 000000	0	0	90. 01
01 00 00100 EMEDGENCY		0 10//1/	ما م		01 00

0 90. 01 0 91. 00 0 92. 00 245, 419 200. 00

201. 00 202. 00

0. 000000 0. 196619

0.813500

1, 215, 410

91. 00 09100 EMERGENCY

200.00

201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

Health Financi	ial Systems	SALEM TOWNSHIP HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1345	Peri od:	Worksheet D-3	
				From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9:2	
		Ti tl	e XIX	Hospi tal	Cost	
C	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	ENT ROUTINE SERVICE COST CENTERS					1
	ADULTS & PEDIATRICS			0		30.00
	ARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 18633		0	
	NESTHESI OLOGY		0.00000		0	
	RADI OLOGY-DI AGNOSTI C		0. 17467		0	
57. 00 05700 C			0. 02159		0	
58.00 05800 M			0. 03518		0	58.00
	ABORATORY		0. 11926		0	60.00
	RESPI RATORY THERAPY		0. 22181		0	65.00
	PHYSI CAL THERAPY		0. 25223		0	66.00
	OCCUPATI ONAL THERAPY		0. 18619		0	67.00
	SPEECH PATHOLOGY		0. 46737		0	68.00
	ELECTROCARDI OLOGY		0. 03976		0	
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 48875		0	
	MPL. DEV. CHARGED TO PATIENTS		0. 82620		0	
	DRUGS CHARGED TO PATIENTS		0. 42347		0	
	BEHAVI ORAL HEALTH		0. 62180	0 8	0	76. 00
	ENT SERVICE COST CENTERS			,-l		
	RURAL HEALTH CLINIC		0. 95977		0	
	RURAL HEALTH CLINIC II		1. 55620		0	
90.00 09000 0			0. 53646		0	90.00
	SALEM MEDICAL CLINIC		0.00000		0	90.01
	EMERGENCY		0. 1966		0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART	(thank 00)	0. 81350	0	0	, 2. 00
	otal (sum of lines 50 through 94 and 96			0		200.00
201. 00 L	ess PBP Clinic Laboratory Services-Produces	aram only charges (line 61)	1	0		201 00

201. 00 202. 00

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

201.00 202.00

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu of Form CMS-25	52-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-134	From 04/01/2022 Part B To 03/31/2023 Date/Time Prepa 8/29/2023 9: 20	
	T1 11 \0.011		

	Title XVIII Hospital	Cost	<u>o alli</u>
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1. 00	
1. 00	Medical and other services (see instructions)	7, 536, 509	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	
3.00	OPPS or REH payments	0	
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)	0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	1
6.00	Line 2 times line 5	0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00	Organ acqui si ti ons	Ö	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7, 536, 509	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		-
12. 00	Reasonable charges Ancillary service charges	1 0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	o o	1
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
15 00	Customary charges		15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis Amounts that would have been realized from patients liable for payment for services on a chargebasi	1	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	
	Total customary charges (see instructions)	0	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19. 00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
04.00	instructions)	7 (44 07)	04.00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)	7, 611, 874	
	Cost of physicians' services in a teaching hospital (see instructions)		1
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	68, 864 6, 787, 954	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	755, 056	1
	instructions)	133,333	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
	REH facility payment amount ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28. 50 29. 00
	Subtotal (sum of lines 27, 28, 28.50 and 29)	755, 056	1
31.00	Pri mary payer payments	0	31.00
32. 00	Subtotal (line 30 minus line 31)	755, 056	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	20, 722	
35. 00	Adjusted reimbursable bad debts (see instructions)	13, 469	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	7/0 505	
37.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	768, 525 0	
39. 00	OTHER ADJUSTMENTS	89, 451	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	1
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	o o	39. 99
40.00		857, 976	
40. 01	Sequestration adjustment (see instructions)	15, 015	1
40. 02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs	0	40. 02 40. 03
	Interim payments	3, 200, 369	
41. 01	Interim payments-PARHM		41. 01
42.00	Tentative settlement (for contractors use only)	0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)	-2, 357, 408	42. 01 43. 00
43. 01	Balance due provider/program-PARHM (see instructions)	2, 337, 400	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
	§115. 2		1
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	
92. 00	The rate used to calculate the Time Value of Money	0.00	92.00
	Time Value of Money (see instructions)	0	1
74 . UU	Total (sum of lines 91 and 93)	1 0	94.00

Health Financial Systems	SALEM TOWNSHIP H	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 04/01/2022		
			To 03/31/2023		
				8/29/2023 9:	<u>20 am</u>
		Title XVIII	Hospi tal	Cost	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Health Financial Systems SALI
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 04/01/2022 Part I
To 03/31/2023 Date/Time Prepared: 8/29/2023 9: 20 am Provider CCN: 14-1345

					8/29/2023 9: 20	0 am
			XVIII	Hospi tal	Cost	
		Inpati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 882, 08	4	4, 468, 071	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	09/26/2022	44, 02		36, 245	3. 01
3. 02		11/08/2022	144, 15		0	3. 02
3. 03				0	0	3. 03
3. 04				0	0	3. 04
3. 05				0	0	3. 05
	Provi der to Program	<u> </u>		11 (00 (0000	1 0/0 000	
3. 50	ADJUSTMENTS TO PROGRAM			0 11/08/2022	1, 262, 080	3.50
3. 51				0 11/16/2022	41, 867	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3.53
3. 54 3. 99	Subtatal (sum of lines 2.01.2.40 minus sum of lines			0	0	3. 54 3. 99
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		188, 17		-1, 267, 702	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		4, 070, 26	0	3, 200, 369	4. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
- 04	Program to Provi der	<u> </u>				
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Provider to Program			0	0	5. 03
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51	TENTATI VE TO TROUVANI			0		5. 51
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		533, 24		2, 357, 408	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 537, 02		842, 961	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Provider CCN: 14-1345 | Period: From 04/01/2022 | Worksheet E-1 | Part | Date/Time Prepared: 8/29/2023 9:20 am

					8/29/2023 9: 2	0 am
				ving Beds - SNF		
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		1, 353, 189		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	03/07/2023	274, 572		0	3.01
3. 02			0		0	3. 02
3. 03			0		0	3.03
3. 04			0		0	3.04
3. 05			0		0	3.05
	Provi der to Program	11 (00 (0000		<u> </u>		
3.50	ADJUSTMENTS TO PROGRAM	11/08/2022	29, 238		0	3.50
3. 51			0		0	3.5
3. 52			0		0	3. 52
3. 53			0		0	3.5
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		245, 334		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1 500 533		0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 598, 523		U	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		l .			1
5. 00	List separately each tentative settlement payment after		I			5.00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		•			ĺ
5. 01	TENTATI VE TO PROVI DER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5.5
5. 52			0		0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		96, 495		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	
7. 00	Total Medicare program liability (see instructions)		1, 695, 018		0	7.00
				Contractor	NPR Date	
		,		Number 1.00	(Mo/Day/Yr)	
8. 00	Name of Contractor		J	1.00	2. 00	8.00
0.00	INAILE OF CONTRACTOR	I		l		1 0.00

Health Financial Systems SALEM TOWNSHIP HOSPITAL In Lieu				u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-1345	Peri od: From 04/01/2022	Worksheet E-	1
			To 03/31/2023		
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORT	-S			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULA				
1.00	Total hospital discharges as defined in AARA §4102 from \	Wkst. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 20	00			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase	of certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instruction	ns)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions))			30.00
31.00	31.00 Other Adjustment (specify)				
32. 00	Balance due provider (line 8 (or line 10) minus line 30 a	and line 31) (see instructio	ns)		32.00

Health Financial Systems	SALEM TOWNSHIP	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provi der CCN: 14-1345	Peri od: From 04/01/2022	Worksheet E-2
		Component CCN: 14-Z345		

		Component CCN: 14-Z345	Го 03/31/2023	Date/Time Pre 8/29/2023 9:2	
		Title XVIII S	wing Beds - SNF		<u> </u>
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		1, 486, 672	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)	247 072	0	2.00	
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	247, 873	0	3. 00	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swiinstructions)	ng-bed pass-through, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0. 00	4.00
	instructions)	g pg (
5.00	Program days		581	0	5.00
6.00	Interns and residents not in approved teaching program (see i	nstructi ons)		0	6.00
7.00	Utilization review - physician compensation - SNF optional me	thod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 734, 545	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		1, 734, 545	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0	0	11.00
10.00	professional services)		4 704 545		10.00
12.00	Subtotal (line 10 minus line 11)) (avaluda asi nauranaa	1, 734, 545	0	12. 00 13. 00
13. 00	Coinsurance billed to program patients (from provider records for physician professional services)	(exclude collisurance	9, 336	U	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
15. 00	Subtotal (see instructions)		1, 725, 209	0	
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		ŭ	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst		0		16. 55
	adjustment (see instructions)	, 1 3			
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	
19. 00	Total (see instructions)		1, 725, 209	0	
19. 01	Sequestration adjustment (see instructions)		30, 191	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs			0	19.03
19. 25	Sequestration for non-claims based amounts (see instructions)		1 500 533	0	
20. 00 20. 01	Interim payments Interim payments-PARHM		1, 598, 523	U	20. 00 20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	
21. 00	Tentative settlement-PARHM (for contractor use only)			O	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2 19 25 20 and 21)	96, 495	0	
22. 01	Balance due provider/program-PARHM (see instructions)	2, 17. 20, 20, and 21)	70, 170	Ü	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2.	0	0	
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adjustment			Ī
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement		1		
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201. 00
000 00	66 (title XVIII hospital))				000 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m WKST. D−3, COL. 3, IIn∈	1		202. 00
202 00	200 (title XVIII swing-bed SNF)) Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curren	t 5-vear demons	tration	204.00
	period)	The year of the carren	t o your domone		
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				1
207.00	7.00 Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1				208.00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
210.00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
	instructions)		1 1		I

Health Financial Systems	SALEM TOWNSHIP HOSPITAL		In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN		From 04/01/2022 To 03/31/2023	Worksheet E-3 Part V Date/Time Prepared: 8/29/2023 9:20 am
	Ti +l a \	Y\/	Hosni tal	Cost

				8/29/2023 9: 2	<u>0 am</u>
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			3, 852, 051	
2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3.00	Organ acquisition			0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			3, 852, 051	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 890, 572	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7. 00	Routine service charges			0	
8. 00	Ancillary service charges			0	
9. 00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	10.00
44 00	Customary charges				14 00
11.00	Aggregate amount actually collected from patients liable for		9	0	
12. 00	Amounts that would have been realized from patients liable for	1 3	on a charge basis	0	12.00
13. 00	had such payment been made in accordance with 42 CFR 413.13(e Ratio of line 11 to line 12 (not to exceed 1.000000)	;)		0. 000000	13.00
14. 00	Total customary charges (see instructions)			0.000000	
15. 00	Excess of customary charges over reasonable cost (complete or	dy if line 14 evceeds li	na 6) (saa	0	
13.00	instructions)	ily II IIIle 14 exceeds II	116 0) (366		13.00
16. 00	Excess of reasonable cost over customary charges (complete or	lvifline 6 exceeds lin	ne 14) (see	0	16.00
	instructions)	ye e exceede	.0 (000	Ŭ	
17.00					
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	,			1
18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 890, 572	19. 00
20.00	Deductibles (exclude professional component)			294, 376	20.00
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 596, 196	
23. 00	Coinsurance			389	
24.00	Subtotal (line 22 minus line 23)			3, 595, 807	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)			25.00
26. 00	Adjusted reimbursable bad debts (see instructions)			4, 213	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			3, 600, 020	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
29. 98	Recovery of accelerated depreciation.				
29. 99 30. 00	Demonstration payment adjustment amount before sequestration			3, 600, 020	
30. 00	Subtotal (see instructions)			63, 000	1
30. 01					
30. 02	Sequestration adjustment-PARHM			0	30.02
31. 00	Interim payments			4, 070, 260	
	Interim payments-PARHM			4,070,200	31.00
32. 00	Tentative settlement (for contractor use only)			0	
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0)2. 31. and 32)		-533, 240	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		and 32.01)	, - 10	33. 01
34. 00	Protested amounts (nonallowable cost report items) in accorda			0	
	§115. 2		•		
	•				

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1345	Peri od: From 04/01/2022 Part VII To 03/31/2023 Date/Time Prepared: 8/29/2023 9:20 am

			0 03/31/2023	Date/lime Pre 8/29/2023 9:2	
		Title XIX	Hospi tal	Cost	<u> </u>
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		5, 067		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		5, 067	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpati ent pri mary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		5, 067	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		o	0	9.00
10.00	Organ acquisition charges, net of revenue		o		10.00
11.00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		o	0	12.00
	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basis	-			
14.00	Amounts that would have been realized from patients liable for	r payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
16.00	Total customary charges (see instructions)		0	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	0	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds line	5, 067	0	18. 00
	16) (see instructions)			_	
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instr		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line		5, 067	0	21.00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			22 00
	Other than outlier payments		0	0	
	Outlier payments		0	Ü	23.00
	Program capital payments		0		
	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	25. 00 26. 00
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		5, 067	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		5,067	0	29.00
20 00	Excess of reasonable cost (from line 18)		5, 067	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	5, 067	0	
32.00	Deductibles)	5,067	0	
33.00	Coinsurance		0	0	
			0	0	34.00
35.00	Allowable bad debts (see instructions)			U	35.00
	Utilization review Subtatal (sum of lines 21, 24 and 25 minus sum of lines 22 and 22)			0	
37. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		5, 067	0	
	Subtotal (line 36 ± line 37)		5, 067	0	
	Direct graduate medical education payments (from Wkst. E-4)		3,007	U	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		5, 067	0	
41. 00	Interim payments		5, 067	0	1
41.00	Balance due provider/program (line 40 minus line 41)		5,067	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15_2	0	0	
43.00	chapter 1, §115.2	nee with one rub 13-2,		U	1 43.00
	10.1ap.co. 1, 3110.2		1 1		1

Health Financial Systems

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

Provider CCN: 14-1345

Peri od: Worksheet G
From 04/01/2022
To 03/31/2023 Date/Ti me Prepared: 8/29/2023 9: 20 am

OIII y)					8/29/2023 9: 2	0 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	45, 737, 459	1	0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	0	0	0	0	3. 00 4. 00
5.00	Other receivable	42, 437, 641 262, 185	_	0		5.00
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7. 00	Inventory	513, 271	0	0	0	7. 00
8.00	Prepai d expenses	620, 517	0	0	0	8. 00
9.00	Other current assets	25, 000	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	50, 687, 329	0	0	0	11.00
12. 00	Land	203, 353	0	0	0	12.00
13. 00	Land improvements	1, 191, 840		0	1	13.00
14. 00	Accumulated depreciation	-1, 026, 273		0	1	14.00
15.00	Bui I di ngs	35, 375, 964	0	0	0	15. 00
16. 00	Accumulated depreciation	-18, 906, 045	1	0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	2, 829, 195 -2, 010, 198		0	0	19.00 20.00
21. 00	Automobiles and trucks	-2,010,190		0		21.00
22. 00	Accumulated depreciation	0	0	0	Ö	22.00
23. 00	Major movable equipment	11, 883, 149	_	0	Ö	23.00
24.00	Accumul ated depreciation	-9, 471, 923		0	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	042.077	0	0	0	28.00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	843, 977 20, 913, 039		0	0	29. 00 30. 00
30.00	OTHER ASSETS	20, 913, 039	0	0	0	30.00
31.00	Investments	2, 780, 807	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1, 562, 218	1	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4, 343, 025	1	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	75, 943, 393	0	0	0	36.00
37. 00	Accounts payable	1, 799, 313	O	0	0	37.00
38. 00	Salaries, wages, and fees payable	2, 235, 133	1	0	l	38.00
39.00	Payrol I taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	674, 322	0	0	0	40.00
41. 00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43. 00 44. 00	Due to other funds Other current liabilities	5, 431, 579 899, 767		0	0	43. 00 44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 040, 114	1	0	1	45.00
43.00	LONG TERM LIABILITIES	11,040,114	1 9			1 43.00
46. 00	Mortgage payable	13, 505, 469	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47. 00
48. 00	Unsecured Loans	0	0	0		48. 00
49. 00	Other long term liabilities	906, 526		0		49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14, 411, 995	1	0		50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	25, 452, 109	0	0	0	51.00
52. 00	General fund balance	50, 491, 284				52.00
53.00	Specific purpose fund	30, 471, 204	0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	50, 491, 284		^	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	75, 943, 393	1	0		60.00
_0.00	[59]	15,715,575		0		-3.55
		-	. '		-	

Peri od: Worksheet G-1
From 04/01/2022
To 02/21/2023 Date/Time Prep Provider CCN: 14-1345

					To 03/31/2023	Date/Time Pre 8/29/2023 9:2	pared: 0 am
		General	Fund	Special P	Purpose Fund	Endowment Fund	
		1. 00	2.00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CHANGES IN RESTRICTED NET ASSETS	13, 399 0 0 0	35, 524, 174 14, 953, 711 50, 477, 885		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	13, 399 50, 491, 284 0 50, 491, 284		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8.00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CHANGES IN RESTRICTED NET ASSETS	0	0 0 0 0		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0	0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1345

		Т	o 03/31/2023	Date/Time Pre 8/29/2023 9: 2	pared:
	Cost Center Description	I npati ent	Outpati ent	Total	o aiii
		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	11, 160, 282		11, 160, 282	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11, 160, 282		11, 160, 282	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI VE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	0		0	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11, 160, 282		11, 160, 282	17.00
18.00	Ancillary services	11, 814, 220	121, 330, 876	133, 145, 096	18.00
19.00	Outpati ent servi ces	15, 709	1, 080, 394	1, 096, 103	19.00
20.00	RURAL HEALTH CLINIC	0	3, 357, 099	3, 357, 099	20.00
20. 01	RURAL HEALTH CLINIC II	0	1, 482, 594	1, 482, 594	20. 01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPI CE				26.00
27.00	PROFESSI ONAL FEES	861, 709	7, 824, 898	8, 686, 607	27.00
27. 01	OTHER (SPECIFY)	0	0	0	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	23, 851, 920	135, 075, 861	158, 927, 781	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		38, 433, 695		29. 00
30.00	ADD (SPECIFY)	0			30. 00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38. 00
39. 00		0			39.00
40.00		0			40. 00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		38, 433, 695		43.00
	to Wkst. G-3, line 4)	I	ı I		

Heal th Financial Systems SALEM TOWNSHIP HOSPITAL In Lie Unit Form CMS-2552-10		CALENT TOWNSHIP	HOODITAL		. C. F OHC	NEEO 40	
Trom 04/01/2022 To 03/31/2023 Date/Time Prepared: 8/29/2023 9: 20 am 1.00 1.							
1.00	017112.	From 04/01/2022					
1.00				10 03/31/2023			
1.00					0,2,,2020 ,.2	o diii	
2.00 Less contractual allowances and discounts on patients' accounts 110, 602, 457 2.00 Net patient revenues (line 1 minus line 2) 4.00 48, 325, 324 3.00 Net patient revenues (line 1 minus line 2) 4.00 4.00 4.00 4.00 4.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 38, 433, 695 4.00 Net income from service to patients (line 3 minus line 4) 7.00							
3.00 Net patient revenues (line 1 minus line 2) 48, 325, 324 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 33, 433, 695 4.00 5.00 Net income from service to patients (line 3 minus line 4) 9, 891, 629 6.00 Contributions, donations, bequests, etc 55, 200 6.00 7.00 Income from investments 892, 326 7.00 8.00 Revenues from television and radio service 0 8.00 9.00 Revenue from television and radio service 0 9, 90 10.00 Purchase discounts 0 10.00 11.00 Parking lot receipts 0 12.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 15.00 Revenue from meal s old to employees and guests 206,238 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 18.00 Revenue from sale of fedical and surgical supplies to other than patients 0 16.00 18.00 Revenue from sale of fedical records and abstracts 0 18.00 19.00 Tuit ion (fees, sale of textbooks, unif forms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of vending machines 0 22.00 23.00 Governmental appropriations 0 23.00 24.01 MISC REVENUE 12, 450 24.00 PROPERTY TAX INCOME - GENERAL 272, 643 24.00 24.01 MISC REVENUE 12, 450 25.28, 172 25.00 25.00 Total (tline 5 plus line 25) 15, 119, 801 26.00 26.00 Total (tline 5 plus line 25) 15, 119, 801 26.00 Total other expenses (sum of line 27 and subscripts) 166, 699 27.00 Total other expenses (sum of line 27 and subscripts) 166, 699 27.00 Total other expenses (sum of line 27 and subscripts) 166, 699 27.00 Total other expenses (sum of line 27 and subscripts) 166, 699 27.00 Total other expenses (sum of line 27 and subscripts) 166, 699 27.00 Total other expenses							
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 38, 433, 695 4.00 5.00 Net income from service to patients (line 3 minus line 4) 9,891,629 6.00 Contributions, donations, bequests, etc 55,200 6.00 7.00 Income from investments 892,326 7.00 8.00 Revenue from telephone and other miscellaneous communication services 9,892,326 7.00 8.00 Revenue from television and radio service 0,900 9.00 Revenue from television and radio service 0,900 10.00 Purchase discounts 0,900 11.00 Rebates and refunds of expenses 0,100 12.00 Parking lot receipts 0,120 13.00 Revenue from laundry and linen service 0,13.00 14.00 Revenue from meals sold to employees and guests 206,238 14.00 15.00 Revenue from rental of lilving quarters 0,15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0,16.00 17.00 Revenue from sale of medical records and abstracts 0,17.00 18.00 Revenue from sale of textbooks, uniforms, etc. 0,19.00 10.00 Revenue from gifts, flowers, coffee shops, and canteen 0,20.00 10.00 Revenue from gifts, flowers, coffee shops, and canteen 0,20.00 10.00 Rental of hospital space 88,871 22.00 22.00 Rental of hospital space 88,871 22.00 23.00 Governmental appropriations 0,23.00 24.00 ROPEPRTY TAX INCOME - GENERAL 272,643 24.00 24.01 MISC REVENUE 12,450 24.01 24.50 COVID-19 PHE Funding 3,700,444 24.50 25.00 Total other income (sum of lines 6-24) 56,000 26.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00 10.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00 10.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00 10.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00 10.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00 10.00 Tot			nts				
5.00 Net income from service to patients (line 3 minus line 4) 9,891,629 5.00 OTHER INCOME 55,200 6.00 7.00 Income from investments 892,326 7.00 8.00 Revenue from the elevision and radio service 892,326 7.00 8.00 Revenue from television and radio service 0,900 9.00 10.00 Purchase discounts 0,100 11.00 11.00 12.00 Parking lot receipts 0,11.00 12.00 Parking lot receipts 0,12.00 13.00 Revenue from meal's sold to employees and guests 206,238 14.00 15.00 Revenue from meal's sold to employees and guests 206,238 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0,16.00 17.00 Revenue from sale of medical and surgical supplies to other than patients 0,16.00 17.00 18.00 Revenue from sale of medical and surgical supplies to other than patients 0,16.00 17.00 18.00 Revenue from sale of medical records and abstracts 0,18.00 19.00 10							
OTHER INCOME S5, 200 6. 00 7. 00 Contributions, donations, bequests, etc 55, 200 6. 00 8. 00 Revenues from investments 892, 326 7. 00 8. 00 Revenue from tell ephone and other miscell aneous communication services 0 8. 00 9. 00 Revenue from tell evils on and radio service 0 9. 00 10. 00 Purchase discounts 0 11. 00 11. 00 Rebates and refunds of expenses 0 11. 00 12. 00 Parking lot receipts 0 11. 00 13. 00 Revenue from laundry and linen service 0 13. 00 14. 00 Revenue from meals sold to employees and guests 206, 238 14. 00 15. 00 Revenue from meals sold to employees and guests 206, 238 14. 00 16. 00 Revenue from rental of living quarters 0 15. 00 16. 00 Revenue from sale of medical and surgical supplies to other than patients 0 15. 00 17. 00 Revenue from sale of medical records and abstracts 0 17. 00 18. 00			43)				
6.00 Contributions, donations, bequests, etc 55,200 6.00 7.00 Income from investments 892,326 7.00 890,000 Revenue from telephone and other miscellaneous communication services 0 9.00 9.00 10.00 Purchase discounts 0 11.00 11.00 11.00 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 13.00 Revenue from meals sold to employees and guests 206,238 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 16.00 Revenue from sale of drugs to other than patients 0 16.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 88.871 22.00 23.00 24.00 Rental of hospital space 88.871 22.00 24.00 RevENUE from sele of textBooks, uniforms 24.00 27.643 24.00 24.00 RevENUE from sele of textBooks 27.2643 24.00 24.00 RevENUE from sele of textBooks 27.2643 24.00 24.00 RevENUE from sele of textBooks 27.2643 24.00 24.00 25.00 RevENUE from sele of textBooks 27.2643 24.00 25.00 Cotal other income (sum of lines 6-24) 5.228,172 25.00 Cotal other income (sum of lines 6-24) 5.228,172 25.00 Cotal other income (sum of lines 6-24) 5.00 Cotal other expenses (sum of line 27 and subscripts) 166,090 28.00 Cotal other expenses (sum of line 27 and subscripts) 166,090 28.00 Cotal other expenses (sum of line 27 and subscripts) 166,090 28.00 Cotal other expenses (sum of line 27 and subscripts) 166,090 28.00 Cotal other expenses (sum of line 27 and subscripts) 166,090 28.00 Cotal other expenses (sum of line 27 and subscripts) 166,090 28.00 Cotal other expenses (sum of line 27 and subscripts) 166,090 28.00 Cotal other expenses (sum of line 27 and subscripts) 166,090 28.00 Cotal other expenses (sum	5.00				9, 891, 629	5.00	
7.00 Income from investments 892,326 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 206,238 14.00 15.00 Revenue from rental of living quarters 206,238 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 15.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of hospital space 88,871 22.00 22.00 Rental of hospital space 88,871 22.00 <td></td> <td></td> <td></td> <td></td> <td>FF 200</td> <td>/ 00</td>					FF 200	/ 00	
8. 00 Revenues from telephone and other miscellaneous communication services 0 8. 00 9. 00 Revenue from television and radio service 0 9. 00 10. 00 Purchase di scounts 0 10. 00 11. 00 Rebates and refunds of expenses 0 11. 00 12. 00 Parking lot receipts 0 12. 00 13. 00 Revenue from laundry and linen service 0 13. 00 14. 00 Revenue from meals sold to employees and guests 206, 238 14. 00 15. 00 Revenue from sale of medical and surgical supplies to other than patients 0 15. 00 16. 00 Revenue from sale of medical records and abstracts 0 17. 00 18. 00 Revenue from sale of drugs to other than patients 0 18. 00 19. 00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19. 00 20. 00 Revenue from gifts, flowers, coffee shops, and canteen 0 20. 00 21. 00 Revenue from gifts, flowers, coffee shops, and canteen 0 21. 00 22. 00 Rental of hospital space 88. 871					·		
9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 10.00 11.00 Rebates and refunds of expenses 0 11.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 206, 238 14.00 15.00 Revenue from sale of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Revenue from gifts, flowers, coffee shops, and canteen 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of hospital space 88,871 22.00 22.00 Rental of hospital space 88,871 22.00 23.00 Reveruer from gifts, flowers, coffee shops, and canteen 272,643 24.00 <td></td> <td></td> <td>a condicac</td> <td></td> <td></td> <td></td>			a condicac				
10.00 Purchase discounts			1 Services		- 1		
11.00 Rebates and refunds of expenses 0 11.00 12.00 12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 13.00 Revenue from meals sold to employees and guests 206, 238 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 18.00 18.00 19.0					-		
12.00 Parking lot receipts 0 12.00 13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 206,238 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 88,871 22.00 23.00 Governmental appropriations 0 23.00 24.00 PROPERTY TAX INCOME - GENERAL 272,643 24.00 24.01 MISC REVENUE 12,450 24.01 24.50 COVID-19 PHE Funding 3,700,444 24.50 25.00 Total other income (sum of lines 6-24) 5,228,172 25.00 26.00 Total (line 5 plus line 25) 15,119,801 26.00 27.00 GAIN/LOSS ON SALE OF ASSETS 166,090 28.00					-		
13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 206, 238 14.00 15.00 Revenue from rental of living quarters 0 15.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 10.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 10.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 88,871 22.00 23.00 Governmental appropriations 0 23.00 24.00 PROPERTY TAX INCOME - GENERAL 272,643 24.00 24.50 COVID-19 PHE Funding 3,700,444 24.50 25.00 Total other income (sum of lines 6-24) 5, 228,172 25.00 26.00 Total (line 5 plus line 25) 15, 119,801 26.00 27.00 GAIN/LOSS ON SALE OF ASSETS 166,090 28.00 28.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00					-		
14. 00 Revenue from meal's sold to employees and guests 206, 238 14. 00 15. 00 Revenue from rental of living quarters 0 15. 00 16. 00 Revenue from sale of medical and surgical supplies to other than patients 0 16. 00 17. 00 Revenue from sale of medical records and abstracts 0 17. 00 18. 00 Revenue from gale of medical records and abstracts 0 18. 00 19. 00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19. 00 20. 00 Revenue from gifts, flowers, coffee shops, and canteen 0 20. 00 21. 00 Rental of vending machines 0 21. 00 22. 00 Rental of hospital space 88, 871 22. 00 23. 00 Governmental appropriations 0 27. 04 24. 00 PROPERTY TAX INCOME - GENERAL 272, 643 24. 00 24. 01 MI SC REVENUE 12, 450 24. 01 25. 00 Total other income (sum of lines 6-24) 5, 228, 172 25. 00 26. 00 Total (line 5 plus line 25) 15, 119, 801 26. 00 27. 00 GAIN/LOSS ON SALE OF ASSETS 166, 090					ŭ		
15. 00 Revenue from rental of living quarters 16. 00 Revenue from sale of medical and surgical supplies to other than patients 17. 00 Revenue from sale of drugs to other than patients 18. 00 Revenue from sale of drugs to other than patients 19. 00 Tuition (fees, sale of textbooks, uniforms, etc.) 19. 00 Revenue from gifts, flowers, coffee shops, and canteen 19. 00 Rental of vending machines 19. 00 Rental of vending machines 19. 00 Rental of hospital space 20. 00 Revenue from gifts, flowers, coffee shops, and canteen 20. 00 Rental of vending machines 21. 00 Rental of vending machines 22. 00 Rental of hospital space 23. 00 Revenue from gifts, flowers, coffee shops, and canteen 24. 00 Revenue from gifts, flowers, coffee shops, and canteen 25. 00 Revenue from gifts, flowers, coffee shops, and canteen 26. 00 Revenue from sale of medical records and abstracts 27. 04. 01 P.00 28. 00 Revenue from sale of medical records and subscripts 28. 00 Total other income (sum of lines 6-24) 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Salvy Income flowers, coffee shops, and canteen 29. 00 Sal					- 1		
16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 88,871 22.00 23.00 Governmental appropriations 0 23.00 24.00 PROPERTY TAX INCOME - GENERAL 272,643 24.00 24.50 COVID-19 PHE Funding 3,700,444 24.50 25.00 Total other income (sum of lines 6-24) 5,228,172 25.00 25.00 Total (line 5 plus line 25) 15,119,801 26.00 27.00 GAIN/LOSS ON SALE OF ASSETS 166,090 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00							
17. 00 Revenue from sale of drugs to other than patients 0 17. 00 18. 00 Revenue from sale of medical records and abstracts 0 18. 00 19. 00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19. 00 20. 00 Revenue from gifts, flowers, coffee shops, and canteen 0 20. 00 21. 00 Rental of vending machines 0 21. 00 22. 00 Rental of hospital space 88, 871 22. 00 23. 00 Governmental appropriations 0 23. 00 24. 00 PROPERTY TAX INCOME - GENERAL 272, 643 24. 00 24. 50 COVI D-19 PHE Funding 3, 700, 444 24. 50 25. 00 Total other income (sum of lines 6-24) 5, 228, 172 25. 00 26. 00 Total (line 5 plus line 25) 15, 119, 801 26. 00 27. 00 GAIN/LOSS ON SALE OF ASSETS 166, 090 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 166, 090 28. 00			than patients				
18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 88,871 22.00 23.00 Governmental appropriations 0 23.00 24.00 PROPERTY TAX INCOME - GENERAL 272,643 24.00 24.01 MI SC REVENUE 12,450 24.01 24.50 COVI D-19 PHE Funding 3,700,444 24.50 25.00 Total other income (sum of lines 6-24) 5,228,172 25.00 26.00 Total (line 5 plus line 25) 15,119,801 26.00 27.00 GAIN/LOSS ON SALE OF ASSETS 166,090 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00			than patronto				
19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 88,871 22.00 23.00 Governmental appropriations 0 23.00 24.00 PROPERTY TAX INCOME - GENERAL 272,643 24.00 24.01 MISC REVENUE 24.01 12,450 24.01 25.00 Total other income (sum of lines 6-24) 3,700,444 24.50 25.00 Total (line 5 plus line 25) 15,119,801 26.00 27.00 GAI N/LOSS ON SALE OF ASSETS 166,090 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00					-		
21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 88,871 22.00 23.00 Governmental appropriations 0 23.00 24.00 PROPERTY TAX INCOME - GENERAL 272,643 24.00 24.01 MISC REVENUE 12,450 24.01 25.00 COVID-19 PHE Funding 3,700,444 24.50 25.00 Total other income (sum of lines 6-24) 5,228,172 25.00 26.00 Total (line 5 plus line 25) 15,119,801 26.00 27.00 GAIN/LOSS ON SALE OF ASSETS 166,090 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00	19. 00				0	19.00	
21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 88,871 22.00 23.00 Governmental appropriations 0 23.00 24.00 PROPERTY TAX INCOME - GENERAL 272,643 24.00 24.01 MISC REVENUE 12,450 24.01 25.00 COVID-19 PHE Funding 3,700,444 24.50 25.00 Total other income (sum of lines 6-24) 5,228,172 25.00 26.00 Total (line 5 plus line 25) 15,119,801 26.00 27.00 GAIN/LOSS ON SALE OF ASSETS 166,090 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00	20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
23. 00 Governmental appropriations 24. 00 PROPERTY TAX INCOME - GENERAL 24. 01 MI SC REVENUE 25. 00 COVID-19 PHE Funding 26. 00 Total other income (sum of lines 6-24) 27. 00 GAI N/LOSS ON SALE OF ASSETS 28. 00 Total other expenses (sum of line 27 and subscripts) 29. 00 Total other expenses (sum of line 27 and subscripts) 20. 00 Total other expenses (sum of line 27 and subscripts) 20. 00 Total other expenses (sum of line 27 and subscripts) 20. 00 Total other expenses (sum of line 27 and subscripts)	21.00	Rental of vending machines			0	21.00	
24. 00 PROPERTY TAX INCOME - GENERAL 272, 643 24. 00 24. 01 MI SC REVENUE 12, 450 24. 01 24. 50 COVI D-19 PHE Funding 3, 700, 444 24. 50 25. 00 Total other income (sum of lines 6-24) 5, 228, 172 25. 00 26. 00 Total (line 5 plus line 25) 15, 119, 801 26. 00 27. 00 GAI N/LOSS ON SALE OF ASSETS 166, 090 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 166, 090 28. 00	22.00	Rental of hospital space			88, 871	22.00	
24. 01 MISC REVENUE 12, 450 24. 01 24. 50 COVI D-19 PHE Funding 3, 700, 444 24. 50 25. 00 Total other income (sum of lines 6-24) 5, 228, 172 25. 00 26. 00 Total (line 5 plus line 25) 15, 119, 801 26. 00 27. 00 GAI N/LOSS ON SALE OF ASSETS 166, 090 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 166, 090 28. 00	23.00	Governmental appropriations			0	23.00	
24. 50 COVID-19 PHE Funding 3,700,444 24. 50 25. 00 Total other income (sum of lines 6-24) 5,228,172 25. 00 26. 00 Total (line 5 plus line 25) 15,119,801 26. 00 27. 00 GAIN/LOSS ON SALE OF ASSETS 166,090 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 166,090 28. 00	24.00	PROPERTY TAX INCOME - GENERAL			272, 643	24.00	
25. 00 Total other income (sum of lines 6-24) 5, 228, 172 25. 00 26. 00 Total (line 5 plus line 25) 15, 119, 801 26. 00 27. 00 GAI N/LOSS ON SALE OF ASSETS 166, 090 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 166, 090 28. 00	24.01	MI SC REVENUE			12, 450	24. 01	
26. 00 Total (line 5 plus line 25) 27. 00 GAIN/LOSS ON SALE OF ASSETS 28. 00 Total other expenses (sum of line 27 and subscripts) 15, 119, 801 26. 00 166, 090 27. 00 166, 090 28. 00	24.50	COVI D-19 PHE Fundi ng			3, 700, 444	24.50	
27.00 GAIN/LOSS ON SALE OF ASSETS 166,090 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00	25.00	Total other income (sum of lines 6-24)			5, 228, 172		
28.00 Total other expenses (sum of line 27 and subscripts) 166,090 28.00					15, 119, 801	26.00	
29.00 Net income (or loss) for the period (line 26 minus line 28) 14,953,711 29.00					·		
	29. 00	Net income (or loss) for the period (line 26 minus line 28)			14, 953, 711	29. 00	

	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	SALEM TOWNSHI	P HOSPITAL Provi der C	ON: 14 124E	In Lie Period:	u of Form CMS-2 Worksheet M-1	
ANALTS	SIS OF HOSPITAL-BASED KHC/FUHC COSTS		Provider C	CN. 14-1343	From 04/01/2022	WOI KSHEEL W-1	
			Component	CCN: 14-3413	To 03/31/2023	Date/Time Pre 8/29/2023 9:2	
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1 00	2.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00		450 454	440 141	926. 79	212	024 502	1.00
2. 00	Physi ci an Physi ci an Assi stant	458, 654 0	468, 141	920, 79	-212 0 0	926, 583 0	2.00
3. 00	Nurse Practitioner	510, 466	35, 243	545, 70	-	545, 668	
4. 00	Visiting Nurse	510, 400	35, 243	343, 70	0 -41	0 345,008	1
5. 00	Other Nurse	0	0		0	0	
6. 00	Clinical Psychologist	0	0		0 0	0	1 0.00
7. 00	Clinical Social Worker	0	0		0 0	0	
8. 00	Laboratory Techni ci an	0	0		0 0	Ö	
9. 00	Other Facility Health Care Staff Costs	424, 136	29, 283	453, 41	٦	453, 419	1
10. 00	Subtotal (sum of lines 1 through 9)	1, 393, 256	532, 667			1, 925, 670	
11. 00	Physician Services Under Agreement	0	0	1,720,72	0 0	0	11.00
12. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	14.00
15.00	Medical Supplies	0	27, 423	27, 42	3 0	27, 423	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0		0	0	17. 00
18. 00	,	0	0		0	0	
19. 00	Other Health Care Costs	0	0		0	0	
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	27, 423			27, 423	
22. 00	Total Cost of Health Care Services (sum of	1, 393, 256	560, 090	1, 953, 34	-253	1, 953, 093	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	0	0		0 0	0	
25. 00	Optometry	0	0		0 0	0	
25. 00	Tel eheal th	0	0		0 253	253	
25. 02	Chronic Care Management	0	0		0 0	0	1
26. 00	All other nonreimbursable costs	0	0		0 0	o o	1
27. 00	Nonallowable GME costs	Ö				Ĭ	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 253	253	
	through 27)	_	_				
	FACILITY OVERHEAD				•		1
29. 00	Facility Costs	0	3, 862	3, 86	2 0	3, 862	29. 00
30.00	Administrative Costs	0	26, 108	26, 10	0 8	26, 108	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	29, 970	29, 97	0	29, 970	31.00
	(30)			I	1	I	1

1, 393, 256

590, 060

1, 983, 316

0

32.00

1, 983, 316

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1345	Peri od: From 04/01/2022	Worksheet M-1
	Component CCN: 14-3413	To 03/31/2023	Date/Time Prepared: 8/29/2023 9:20 am
		DUC I	Coot

			Component	CCN. 14-3413	10 03/31/2023	8/29/2023 9: 2	
					RHC I	Cost	
		Adjustments	Net Expenses		<u>'</u>		
		,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	926, 583				1.00
2.00	Physician Assistant	o	0				2.00
3.00	Nurse Practitioner	o	545, 668				3.00
4.00	Visiting Nurse	0	0)			4.00
5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	0				7. 00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	453, 419				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 925, 670				10.00
11.00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	o	0				14.00
15.00	Medical Supplies	1, 523	28, 946				15.00
16.00	Transportation (Health Care Staff)	o	0				16. 00
17.00	Depreciation-Medical Equipment	o	0				17. 00
18.00	Professional Liability Insurance	o	0				18. 00
19.00	Other Health Care Costs	0	0				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	1, 523	28, 946				21.00
22.00	Total Cost of Health Care Services (sum of	1, 523	1, 954, 616				22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	1 -	0	0				23.00
24.00	Dental	0	0	1			24. 00
25.00	Optometry	0	0				25. 00
25. 01	Tel eheal th	0	253				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	253				28. 00
	through 27)						
	FACILITY OVERHEAD	1					
	Facility Costs	0	3, 862				29. 00
30.00	Administrative Costs	0	26, 108				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	29, 970	1			31.00
00.00	30)	4 500	4 004 000				00.00
32. 00	, ,	1, 523	1, 984, 839	Ί			32.00
	and 31)	l		I			1

	Financial Systems	SALEM TOWNSHI				u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1345	Peri od:	Worksheet M-1	
			Component	CCN: 14-8608	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9:2	
					RHC II	Cost	
		Compensation	Other Costs		1 Reclassi fi cat		
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2. 00	3.00	4.00	col . 4) 5.00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
1. 00	Physi ci an	333, 852	21, 775	355, 62	-211	355, 416	1.00
2. 00	Physician Assistant	333, 632	21,773	1	0 -211	333,410	1
3. 00	Nurse Practitioner	275, 804	17, 989	1	0	293, 571	3.00
4. 00	Visiting Nurse	270,001	17,707	2,0,7.	0 0	0	
5. 00	Other Nurse	0	Ö		0 0	0	
6. 00	Clinical Psychologist	0	Ö		0 0	Ō	
7. 00	Clinical Social Worker	0	Ö	i	o o	Ō	1
8. 00	Laboratory Techni ci an	0	0	,	0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	575, 923	37, 564	613, 48	37 0	613, 487	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 185, 579				1, 262, 474	10.00
11.00	Physician Services Under Agreement	0	0		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	0)	0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	25, 964	25, 96	0	25, 964	15.00
16.00	Transportation (Health Care Staff)	0	0	1	0	0	
17. 00	Depreciation-Medical Equipment	0	0	1	0	0	
18. 00	Professional Liability Insurance	0	0	1	0	0	
19. 00	Other Health Care Costs	0	0		0	0	
20. 00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	25, 964			25, 964	1
22. 00	Total Cost of Health Care Services (sum of	1, 185, 579	103, 292	1, 288, 87	-433	1, 288, 438	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0	ı	0 0	0	23. 00
24.00	Dental	0		1	0 0		
25. 00	Optometry	0				0	
25. 01	Tel eheal th	0			0 433		
25. 02	Chronic Care Management	0			0 0	l	
26. 00	All other nonreimbursable costs	0	0		0 0	o o	
27. 00	Nonal Lowable GME costs	Ö			٦	Ĭ	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	,	0 433	433	
	through 27)				1		
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7, 616	7, 61	6 0	7, 616	29. 00
30.00	Administrative Costs	0	26, 237			26, 237	
31.00	Total Facility Overhead (sum of lines 29 and	0	33, 853	33, 85	53 0	33, 853	31.00
	30)			I		I	I

1, 185, 579

1, 322, 724

1, 322, 724

32.00

137, 145

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	SALEM TOWNSHIP HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1345	Peri od: Worksheet M-1 From 04/01/2022
	Component CCN: 14-8608	To 03/31/2023 Date/Time Prepared: 8/29/2023 9: 20 am

			Component Con.	11 0000	10	03/31/2023	8/29/2023 9: 2	
						RHC II	Cost	
		Adjustments	Net Expenses					
		,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	355, 416					1.00
2.00	Physician Assistant	o	0					2.00
3.00	Nurse Practitioner	o	293, 571					3.00
4.00	Visiting Nurse	o	0					4.00
5.00	Other Nurse	0	0					5.00
6.00	Clinical Psychologist	0	0					6.00
7. 00	Clinical Social Worker	0	0					7. 00
8. 00	Laboratory Techni ci an	0	0					8.00
9. 00	Other Facility Health Care Staff Costs	0	613, 487					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 262, 474					10.00
11. 00	, , ,	0	0					11.00
12.00		0	o					12.00
13. 00		0	0					13.00
14. 00	Ŭ .	0	0					14.00
15. 00	, ,	5, 897	31, 861					15.00
16. 00	1 ''	3, 647	31, 801					16.00
17. 00	1 ' ' '	0	0					17.00
18.00	1 '	0	0					18.00
	Other Health Care Costs	0	0					19.00
20.00		U	U					20.00
21.00		5, 897	31, 861					21.00
21.00		5, 897 5, 897	1, 294, 335					22.00
22.00	lines 10, 14, and 21)	5, 897	1, 294, 335					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
22 00	Pharmacy	0	0					23. 00
24.00	1 7	0	0					24.00
25.00		0	0					25.00
25. 00	1 '	0	433					25. 00
25. 01		0	0					25. 01
26. 00	9	0	0					26.00
26.00		U	U					27.00
		0	422					28.00
28. 00	`	U	433					28.00
	through 27)							-
20.00	FACILITY OVERHEAD	O	7 (1)					29.00
	Facility Costs		7, 616					
30.00		0	26, 237					30.00
31. 00	` `	O	33, 853					31.00
22.00	30)	E 007	1 220 (21					22.00
32. 00	•	5, 897	1, 328, 621					32.00
	and 31)	I						I

Number of FTE Personnel Number of FTE Number of FTE Personnel Number of FTE Number of PTE Number of PTE Number of PTE Number of FTE Number of Number	Heal th	Financial Systems	SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CMS-2	2552-10
Number of FTE Personnel Number of FTE Standard (1) Number of Standard (1) Number of FTE Standard (1) Number of Standard	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C			Worksheet M-2	
Number of FTE Total Visits Productivity Minimum Greater of col. 2 or col. 4				Component		To 03/31/2023		
Personnel Standard (1) Visits (col. col. 2 or							Cost	
No				Total Visits				
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)			
VISITS AND PRODUCTIVITY								
Desitions			1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 Physician								
2. 00 Physician Assistant			_					
3.00 Nurse Practitioner 2.49 12,753 2,100 5,229 3.00 4.00 5.00 4.00 5.00 Visiting Nurse 0.00 0 0.0								
4.00 Subtotal (sum of lines 1 through 3) 3.69 15,044 10,269 15,044 4.00 5.00 Visiting Nurse 0.00 0 0 0 0 5.00 Visiting Nurse 0.00 0 0 0 0 5.00 Clinical Psychologist 1.90 544 544 6.00 7.00 Clinical Social Worker 0.95 113 113 7.00 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 0 0 7.01 Diabetes Self Management Training (FOHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
5.00 Visiting Nurse 0.00 0 0 5.00 6.00 Clinical Psychologist 1.90 544 544 6.00 7.00 Clinical Social Worker 0.95 113 113 7.00 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 0 7.01 7.02 Diabetes Self Management Training (FOHC 0.00 0 0 0 0 7.02 8.00 Total FTEs and Visits (sum of lines 4 6.54 15,701 15,701 8.00 1.00 Physician Services Under Agreements 243 243 243 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1.00 11.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,954,616 10.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,954,869 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 0.999871 13.00 14.00 Total hospital-based RHC/FOHC services (line 10 divided by line 12) 0.999871 13.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,237,228 15.00 16.00 Total overhead (sum of lines 14 and 15) 1,267,198 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,267,035 19.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 1,267,035 19.00 10.00 1,267,035 19.00 10.			1					
6.00 Clinical Psychologist 1.90 544 6.00 7.00 Clinical Social Worker 0.95 113 113 7.00 Poly Medical Nutrition Therapist (FQHC only) 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					•	10, 269		
7. 00 Clinical Social Worker 0.95 113 7. 00 7. 01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 7. 01 0 7. 01 0 1 1 1 1 1 1 1 1					l .		-	
7. 01 Medical Nutrition Therapist (FQHC only)								
7. 02 Diabetes Self Management Training (FOHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	l .	•			
Solid Soli							-	
8.00 Total FTEs and Visits (sum of lines 4 through 7) 9.00 Physician Services Under Agreements 243 243 243 243 243 243 240 243 240 243 240 243 240 243 243	7. 02		0.00	0			0	7. 02
through 7) Physician Services Under Agreements 243 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 1.00 1.0								
9.00 Physician Services Under Agreements 243 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 1.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,954,616 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 253 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,954,869 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 0.999871 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 29,970 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,237,228 15.00 17.00 Allowable GME overhead (see instructions) 0 17.00 17.00 Robert Head (see instructions) 1,267,198 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,267,035 19.00 1	8. 00		6. 54	15, 701			15, 701	8. 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 1,954,616 10.00								
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,954,616 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 253 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,954,869 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 0.999871 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 29,970 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,237,228 15.00 17.00 Allowable GME overhead (see instructions) 1,267,198 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,267,198 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,267,035 19.00 19.	9. 00	Physician Services Under Agreements		243			243	9.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,954,616 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 253 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,954,869 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 0.999871 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 29,970 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,237,228 15.00 17.00 Allowable GME overhead (see instructions) 1,267,198 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,267,198 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,267,035 19.00 19.								
10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,954,616 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 253 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,954,869 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 0.999871 13.00 15.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 29,970 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,237,228 15.00 16.00 Total overhead (sum of lines 14 and 15) 1,267,198 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,267,198 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,267,035 19.00		·					1. 00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 253 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,954,869 12.00 13.00 Ratio of hospital -based RHC/FQHC services (line 10 divided by line 12) 0.999871 13.00 14.00 Total hospital -based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 29,970 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,237,228 15.00 16.00 Total overhead (sum of lines 14 and 15) 1,267,198 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,267,198 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,267,035 19.00					RVI CES			
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 1,954,869 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1, 267, 035 19.00								1
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 10.999871 13.00 29,970 14.00 1,237,228 15.00 1,267,198 18.00 1,267,198 18.00		,	· ·	,				1
Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 29,970								1
Parent provider overhead allocated to facility (see instructions) 1, 237, 228 15.00 10.00 Total overhead (sum of lines 14 and 15) 1, 267, 198 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1, 267, 198 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1, 267, 035 19.00								
16.00 Total overhead (sum of lines 14 and 15) 1, 267, 198 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1, 267, 198 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1, 267, 035 19.00								
17. 00 Allowable GME overhead (see instructions) 18. 00 Enter the amount from line 16 19. 00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 17. 00 17. 00 1, 267, 198 18. 00 1, 267, 035 19. 00								1
18.00 Enter the amount from line 16 1,267,198 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,267,035 19.00								
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,267,035 19.00								
								1
20.00 total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 3,221,651 20.00								
	20. 00	lotal allowable cost of hospital-based RHC/F	·UHC services (sum of lines 1	U and 19)		3, 221, 651	20.00

Heal th	Financial Systems	SALEM TOWNSH	IP HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 14-8608	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9:2	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions	1	1	1			
1.00	Physi ci an	1. 31					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	1.87				0.420	3.00
4.00	Subtotal (sum of lines 1 through 3)	3. 18		•	9, 429	9, 429	
5. 00 6. 00	Visiting Nurse Clinical Psychologist	0. 00 0. 00				0	5. 00 6. 00
7. 00	Clinical Social Worker	0.00				0	7.00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.00
7. 01	Di abetes Self Management Training (FQHC	0.00				0	7.01
7.02	only)	0.00				U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	3. 18	5, 985			9, 429	8. 00
0.00	through 7)	0.10	0, 700			,, 12,	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
	,		-				
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			1, 294, 335	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			433	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			1, 294, 768	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 999666	13.00
14.00	14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					33, 853	
15.00						978, 595	
16.00	Total overhead (sum of lines 14 and 15)					1, 012, 448	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					1, 012, 448	
	Overhead applicable to hospital-based RHC/FQ					1, 012, 110	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	U and 19)	l	2, 306, 445	20.00

			6.5. 040.6					
	Financial Systems SALEM TOWNSHIP HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC Provider CCN: 14-1345	Peri od:	u of Form CMS-2 Worksheet M-3					
	SERVI CES Component CCN: 14-3413 From 04/01/2022 To 03/31/2023							
-								
	THE WITH	1010	0031					
			1. 00					
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES							
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)		3, 221, 651	1.00				
2. 00 3. 00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15) Total allowable cost excluding injections/infusions (line 1 minus line 2)		2, 918 3, 218, 733	2. 00 3. 00				
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)		15, 701	4.00				
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		243	5.00				
6.00	Total adjusted visits (line 4 plus line 5)		15, 944	6.00				
7. 00	Adjusted cost per visit (line 3 divided by line 6)		201. 88	7. 00				
		Cal cul ati on	of Limit (1)					
		Rate Period 1	Rate Period 2					
		(04/01/2022	(01/01/2023					
		through	through					
		12/31/2022)	03/31/2023)					
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	1. 00	2. 00 210. 59	8. 00				
9. 00	Rate for Program covered visits (see instructions)	201. 88						
7. 00	CALCULATION OF SETTLEMENT	201.00	201.00	7.00				
10.00	Program covered visits excluding mental health services (from contractor records)	1, 449	474	10.00				
11. 00	Program cost excluding costs for mental health services (line 9 x line 10)	292, 524	95, 691					
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00				
13. 00 14. 00	Program covered cost from mental health services (line 9 x line 12) Limit adjustment for mental health services (see instructions)	0	0	13. 00 14. 00				
15. 00	Graduate Medical Education Pass Through Cost (see instructions)	0	0	15.00				
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	388, 215					
16. 01	Total program charges (see instructions)(from contractor's records)		433, 218	16. 01				
16. 02	Total program preventive charges (see instructions)(from provider's records)		32, 454	•				
16. 03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		29, 083	16.03				
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		260, 007	16. 04				
16. 05	Total program cost (see instructions)	0	289, 090	16. 05				
17.00	Pri mary payer amounts		0	17. 00				
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor		34, 123	18. 00				
10.00	records)		70 7/1	10.00				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		72, 761	19. 00				
20.00	Net Medicare cost excluding vaccines (see instructions)		289, 090	20. 00				
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		206	21.00				
22. 00	Total reimbursable Program cost (line 20 plus line 21)		289, 296					
23. 00	Allowable bad debts (see instructions)		322					
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions)		209	23. 01 24. 00				
	Allowable bad debts for dual eligible beneficiaries (see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00				
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25. 50				
25. 99	Demonstration payment adjustment amount before sequestration		0					
26.00	Net reimbursable amount (see instructions)		289, 505	1				
26. 01	Sequestration adjustment (see instructions)		5, 067 0	1				
26. 02								
27. 00 28. 00				1				
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		0 28, 476	•				
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-I	Ι,	0	•				
	chapter I, §115.2							

	Financial Systems SALEM TOWNSHIP HOS ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC P		In Lie	u of Form CMS-2	
SERVI (ES	Component CCN: 14-1345	From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Pre 8/29/2023 9:2	pared:
		Title XVIII	RHC II	Cost	U alli
	DETERMINATION OF DATE FOR HOCKLIAN DAGED DUG (FOUR CERVILORS			1. 00	
1. 00	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES Total Allowable Cost of hospital-based RHC/FOHC Services (from 1	Wkst M_2 line 20)		2, 306, 445	1.00
2. 00	Cost of injections/infusions and their administration (from Wks			11, 389	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 min			2, 295, 056	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9, 429	4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		0	5.00
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			9, 429 243. 40	6. 00 7. 00
7.00	And distent cost per visit (Title 3 divided by Title 0)		Cal cul ati on		7.00
			Rate Period 1		
			(04/01/2022	(01/01/2023	
			through 12/31/2022)	through 03/31/2023)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	216. 22	224. 44	8. 00
9. 00	Rate for Program covered visits (see instructions)		216. 22	224. 44	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from c	contractor records)	1, 707	558	10.00
11. 00	Program cost excluding costs for mental health services (line 9	•	369, 088	125, 238	
12.00	Program covered visits for mental health services (from contrac		0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line	: 12)	0	0	13. 00
14.00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instructions) Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a		0	494, 326	15.00
16. 01	Total program charges (see instructions) (from contractor's reco	•		537, 355	
16. 02	Total program preventive charges (see instructions) (from provid	•		62, 521	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times I	•		57, 515	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.03	and 18) times .80)		306, 093	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	363, 608	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor		54, 195	18. 00
10.00	records)) (6		02 441	10.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructions records)	(from contractor		83, 441	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			363, 608	20.00
21. 00	Program cost of vaccines and their administration (from Wkst. M	1-4, line 16)		1, 905	•
22. 00	Total reimbursable Program cost (line 20 plus line 21)			365, 513	•
23. 00 23. 01	Allowable bad debts (see instructions)			124 81	
24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		0	23. 01 24. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1011 0113)		0	
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25. 50
25. 99	Demonstration payment adjustment amount before sequestration			0	
26.00	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			365, 594 6, 398	1
26. 01 26. 02	Demonstration payment adjustment amount after sequestration			0, 398	
27. 00	Interim payments			391, 397	
28. 00	,			0	
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.02	· ·		-32, 201	
30. 00	Protested amounts (nonallowable cost report items) in accordance chapter I, §115.2	e with CMS Pub. 15-11,		0	30.00
	Simples: 1, 3110.2		ı	ļ	ļ

	Financial Systems SALEM TOWNSH TATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CC	CN: 14-1345	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component C	CCN: 14-3413	From 04/01/2022 To 03/31/2023	Date/Time Pre 8/29/2023 9:20	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 925, 670 0. 000003	1, 925, 67 0. 00012	· · · · ·	1, 925, 670 0. 000000	
3. 00	<pre>Injection/infusion health care staff cost (line 1 x line 2)</pre>	6	24	41 0	0	3.00
4. 00	Injections/infusions and related medical supplies costs (from your records)	236	1, 28		0	
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	242	1, 52		0	
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 954, 616	1, 954, 61			
7. 00	Total overhead (from Wkst. M-2, line 19)	1, 267, 035	1, 267, 03			
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000124	0. 00078		0. 000000	
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	157	99		0	
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	399	2, 51		0	
11.00	Total number of injections/infusions (from your records)	1		19 0	0	
12.00	Cost per injection/infusion (line 10/line 11)	399.00	51. 4	0.00		12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0		4 0	0	
	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	20	0	0	14.00
					COST OF	
					INJECTIONS /	
					I NFUSI ONS AND	
					ADMINISTRATIO N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administration 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	col umns 1,	1.00	2, 918	15. 00
16 00			s (sum of		206	16 00
. 5. 55	6.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)					

	Financial Systems SALEM TOWNSH ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provi der CO	:N: 14-1345	Peri od:	u of Form CMS-2 Worksheet M-4	
, o o .	THE STATE STOCK THIS THE STOCK THE STOCK			From 04/01/2022		
		Component (CCN: 14-8608	To 03/31/2023	Date/Time Pre 8/29/2023 9: 2	pared: O am
		Title	XVIII	RHC II	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 262, 474 0. 000050	1, 262, 47 0. 00034		1, 262, 474 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	63	43	0	0	3.0
1. 00	Injections/infusions and related medical supplies costs (from your records)	1, 547	4, 35	50 0	0	4.00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	1, 610			0	
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 294, 335	1, 294, 33			
7.00	Total overhead (from Wkst. M-2, line 19)	1, 012, 110				
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 001244	0. 00369	0. 000000	0. 000000	8.0
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	1, 259	3, 73		0	
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2, 869	8, 52		0	
11.00	Total number of injections/infusions (from your records)	13		0	0	
2.00	Cost per injection/infusion (line 10/line 11)	220. 69	96.8	0.00		12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	0		6	0	
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.0
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1, 324	58	0	0	14.0
	and recent desaphroder by				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMINISTRATIO N	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administration		col umns 1,	1.00	11, 389	15.0
, oc	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		. (6		1 005	1,,
6.00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				1, 905	16. (

Health Financial Systems	SALEM TOWNSHIP	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 14-1345 Component CCN: 14-3413		
'				_

		Component CCN. 14-3413	10 03/31/2023	8/29/2023 9: 20	
			RHC I	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			273, 190	1
00	Interim payments payable on individual bills, either submitted	d or to be submitted to		0	2
	the contractor for services rendered in the cost reporting per	riod. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount ba	ased on subsequent			3
	revision of the interim rate for the cost reporting period. Al	Iso show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	3
)2				0	3
)3				0	3
)4				0	3
)5				0	
	Provider to Program				
0			11/08/2022	17, 228	;
1				0	3
2				0	3
3				0	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			-17, 228	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer	r to Worksheet M-3, line	е	255, 962	4
	27)				
	TO BE COMPLETED BY CONTRACTOR		a1		_
00	List separately each tentative settlement payment after desk	review. Also show date o	of		Ę
	each payment. If none, write "NONE" or enter a zero. (1)				
\1	Program to Provider				
)1				0	Ę
)2				0 0	
3	Provider to Program			0	Ę
0	Provider to Program			0	Ę
51					5
52					5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98))			5
0	Determined net settlement amount (balance due) based on the co	,		"	ě
)1	SETTLEMENT TO PROVIDER	031 1 Cp01 1. (1)		28, 476	ć
)2	SETTLEMENT TO PROGRAM			20, 470	6
00	Total Medicare program liability (see instructions)			284, 438	-
	Total medical e program i rabitity (see instructions)		Contractor	NPR Date	
				(Mo/Day/Yr)	
			Numner		
		0	Number 1.00	2.00	

Health Financial Systems	SALEM TOWNSHIP	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provi der CCN: 14-1345 Component CCN: 14-8608		
				_

		Component CCN. 14-8000	10 03/31/2023	8/29/2023 9: 20	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			379, 974	1.0
2. 00	Interim payments payable on individual bills, either submi			0	2.0
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3. 00	List separately each retroactive lump sum adjustment amoun				3. (
	revision of the interim rate for the cost reporting period. Also show date of each				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01			11/08/2022	11, 423	3.
. 02				0	3.
. 03				l ol	3.
3. 04				l ol	3.
. 05				l ol	3.
	Provider to Program				ĺ
. 50	-			0	3.
. 51				l ol	3.
. 52				l ol	3.
. 53				l ol	3.
. 54				l ol	3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		11, 423	3.
1. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			391, 397	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR				İ
5. 00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				ĺ
. 01				0	5.
. 02				0	5.
. 03				0	5.
	Provider to Program				
. 50				0	5.
. 51				0	5.
. 52				l ol	5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	. 98)		o	5.
. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.
. 01	SETTLEMENT TO PROVIDER			o	6.
. 02	SETTLEMENT TO PROGRAM			32, 201	6.
. 00	Total Medicare program liability (see instructions)			359, 196	
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
				(, 5)	
		0	1. 00	2.00	