

State Copy

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).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet S Parts I-III Date/Time Prepared: 8/27/2020 8:32 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 8/27/2020	Time: 8:32 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☒ Cost Report Status	6. Date Received: 09/09/2019	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☒ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☒ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SALEM TOWNSHIP HOSPITAL (14-1345) for the cost reporting period beginning 04/01/2019 and ending 03/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	94,841	-2,126,656	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	89,327	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		24,615		0	10.00
10.01	RURAL HEALTH CLINIC II - FHCC	0		0		0	10.01
200.00	Total	0	184,168	-2,102,041	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 8:32 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1201 RICKER DRIVE			PO Box:				1.00	
2.00	City: SALEM			State: IL		Zip Code: 62881		County: MARION	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			SALEM TOWNSHIP HOSPITAL	141345	99914	1	07/01/1966	N
4.00	Subprovider - IPF							0	0
5.00	Subprovider - IRF								
6.00	Subprovider - (Other)								
7.00	Swing Beds - SNF			SALEM S/B SNF	142345	99914		12/17/1986	N
8.00	Swing Beds - NF							0	N
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC			STH RURAL HEALTH CLINIC	143413	99914		07/29/1996	N
15.01	Hospital-Based Health Clinic - RHC II			STH RURAL HEALTH CLINIC - FHCC	148608	99914		01/30/2020	N
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						04/01/2019	03/31/2020	20.00
21.00	Type of Control (see instructions)						12		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N	N	22.03
23.00	Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.								
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			0	0	0	0	0	0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 8:32 am	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0			25.00
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0			35.00
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.								36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0			37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.								38.00
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N		39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N		40.00
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? 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), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
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.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
					NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion 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 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.					N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
Date/Time Prepared:
8/27/2020 8:32 am

	Y/N	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 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00	2.00	3.00	4.00		
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					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 your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part I
Date/Time Prepared:
8/27/2020 8:32 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
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	65.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
			1.00	2.00	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	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	

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			1.00	2.00	3.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	Y			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 8:32 am	
		Physical 1.00	Occupational 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	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
						1.00	2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
						1.00	2.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	77,017		0	0	118.01	
						1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	Y				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N N				120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 8:32 am	
		1.00		2.00			
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
				1.00			
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y		Y		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If 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)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part I Date/Time Prepared: 8/27/2020 8:32 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)		N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 8:32 am	
				Y/N	Date		
				1.00	2.00		
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 reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			Y			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
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? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)			N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	08/18/2020	Y	08/18/2020 17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			N		N	19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet S-2
Part II
Date/Time Prepared:
8/27/2020 8:32 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		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 (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		Y		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		Y		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		Y		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		Y		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		N		33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		Y		35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
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 prepared by the home office? If yes, see instructions.		N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
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.	ANDREW	MCCABE		41.00
42.00	Enter the employer/company name of the cost report preparer.	WIPFLI			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	715-858-6660	AMCCABE@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet S-2 Part II Date/Time Prepared: 8/27/2020 8:32 am
		3.00		
Cost Report Preparer Contact Information				
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.	CPA		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 8:32 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,150	36,792.00	0	1.00
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 beds) (see instructions)		25	9,150	36,792.00	0	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)		25	9,150	36,792.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						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						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II - FHCC	88.01				0	26.01
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance 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 outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 8:32 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,099	59	1,512		1.00
2.00	HMO and other (see instructions)	154	0			2.00
3.00	HMO IPF Subprovider	0	0			3.00
4.00	HMO IRF Subprovider	0	0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,034	0	1,127		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	35		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,133	59	2,674		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)	2,133	59	2,674	0.00	14.00
15.00	CAH visits	0	0	0		15.00
16.00	SUBPROVIDER - IPF					16.00
17.00	SUBPROVIDER - IRF					17.00
18.00	SUBPROVIDER					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					24.00
24.10	HOSPICE (non-distinct part)			0		24.10
25.00	CMHC - CMHC					25.00
26.00	RURAL HEALTH CLINIC	1,914	0	12,917	0.00	14.32
26.01	RURAL HEALTH CLINIC II - FHCC	0	0	694	0.00	1.14
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	181.63
28.00	Observation Bed Days		0	229		28.00
29.00	Ambulance Trips	0				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)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet S-3
Part I
Date/Time Prepared:
8/27/2020 8:32 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	324	29	488	1.00
2.00 HMO and other (see instructions)			47	0		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						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						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)	0.00	0	324	29	488	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						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						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 - FHCC	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 Ambulance 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)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1345 Component CCN: 14-3413		Period: From 04/01/2019 To 03/31/2020		Worksheet S-8 Date/Time Prepared: 8/27/2020 8:32 am	
				RHC I		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street			1201 RICKER DRIVE			1.00		
			City	State	ZIP Code				
			1.00	2.00	3.00				
2.00	City, State, ZIP Code, County			SALEM IL 62881		2.00			
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0		3.00	
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)							4.00	
5.00	Migrant Health Center (Section 329(d), PHS Act)							5.00	
6.00	Health Services for the Homeless (Section 340(d), PHS Act)							6.00	
7.00	Appalachian Regional Commission							7.00	
8.00	Look-Alikes							8.00	
9.00	OTHER							9.00	
				1.00		2.00			
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0		10.00	
				Sunday		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			09:00	18:30	09:00	18:30	09:00	11.00
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?			N				12.00	
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.			N		0		13.00	
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number							14.00	
				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)							15.00	
				County					
				4.00					
2.00	City, State, ZIP Code, County			MARION				2.00	
				Tuesday	Wednesday	Thursday			
				to	from	to	from	to	
				6.00	7.00	8.00	9.00	10.00	
Facility hours of operations (1)									
11.00	CLINIC			18:30	09:00	18:30	09:00	18:30	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1345	Period: From 04/01/2019	Worksheet S-8	
			Component CCN: 14-3413	To 03/31/2020	Date/Time Prepared: 8/27/2020 8:32 am	
			RHC I			Cost
			Friday		Saturday	
			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

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA				Provider CCN: 14-1345 Component CCN: 14-8608		Period: From 04/01/2019 To 03/31/2020		Worksheet S-8 Date/Time Prepared: 8/27/2020 8:32 am	
				RHC II		Cost			
				1.00					
Clinic Address and Identification									
1.00	Street				1321 W WHITTAKER ST		1.00		
				City		State		ZIP Code	
				1.00		2.00		3.00	
2.00	City, State, ZIP Code, County				SALEM IL 62881		2.00		
				1.00					
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0		3.00		
				Grant Award		Date			
				1.00		2.00			
Source of Federal Funds									
4.00	Community Health Center (Section 330(d), PHS Act)						4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)						5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)						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 hospital-based RHC or FQHC? Enter "Y" 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 hours.)				N		0		10.00
				Sunday		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
				1.00		2.00			
12.00	Have you received an approval for an exception to the productivity standard?				N				12.00
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.				N		0		13.00
				Provider name		CCN number			
				1.00		2.00			
14.00	RHC/FQHC name, CCN number								14.00
				Y/N		V		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)								15.00
				County					
				4.00					
2.00	City, State, ZIP Code, County				MARION				2.00
				Tuesday		Wednesday		Thursday	
				to		from to		from to	
				6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)									
11.00	CLINIC				17:00		08:00		17:00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Provider CCN: 14-1345 Component CCN: 14-8608	Period: From 04/01/2019 To 03/31/2020	Worksheet S-8 Date/Time Prepared: 8/27/2020 8:32 am	
			RHC II		Cost	
			Friday		Saturday	
			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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet S-10 Date/Time Prepared: 8/27/2020 8:32 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.303302 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	4,004,269		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	15,664,865		6.00
7.00	Medicaid cost (line 1 times line 6)	4,751,185		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	746,916		8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
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)	0		11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	746,916		19.00
		Uninsured patients	Insured patients	Total (col. 1 + 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 facility (see instructions)	1,681,006	134,538	1,815,544 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	509,852	134,538	644,390 21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0 22.00
23.00	Cost of charity care (line 21 minus line 22)	509,852	134,538	644,390 23.00
				1.00
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,101,225		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	72,612		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	111,711		27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,989,514		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	642,523		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,286,913		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,033,829		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet A

Date/Time Prepared:
8/27/2020 8:32 am

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,576,599	-291,057	1,285,542	1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2		0	898,891	898,891	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		661,408	28,526	689,934	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	163,161	2,420,991	0	2,584,152	4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	779,685	2,349,904	-660,916	2,468,673	5.01
5.02	00591	BUSINESS SERVICES	420,241	316,302	0	736,543	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	292,130	643,668	0	935,798	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	51,053	20,600	0	71,653	8.00
9.00	00900	HOUSEKEEPING	232,671	86,611	0	319,282	9.00
10.00	01000	DIETARY	284,385	411,236	-572,826	122,795	10.00
11.00	01100	CAFETERIA	0	0	572,826	572,826	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
14.01	01401	PURCHASING	103,558	30,381	0	133,939	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	18,586	1,333	0	19,919	14.02
15.00	01500	PHARMACY	52,381	1,304,173	-86	1,356,468	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,880	77,885	0	316,765	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	530,000	0	530,000	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,733,743	795,313	-24,346	2,504,710	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	656,109	758,638	-224,833	1,189,914	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	568,832	491,470	-70,533	989,769	54.00
57.00	05700	CT SCAN	83,438	99,227	-7,289	175,376	57.00
58.00	05800	MRI	78,000	406,892	-3,660	481,232	58.00
60.00	06000	LABORATORY	621,844	1,138,805	-3	1,760,646	60.00
65.00	06500	RESPIRATORY THERAPY	362,585	197,852	0	560,437	65.00
66.00	06600	PHYSICAL THERAPY	0	494,546	-6	494,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	157,327	0	157,327	67.00
68.00	06800	SPEECH PATHOLOGY	0	350	0	350	68.00
69.00	06900	ELECTROCARDIOLOGY	28,646	45,968	0	74,614	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	-13,632	417,309	403,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	338,429	0	338,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	79,649	49,194	0	128,843	76.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,383,931	357,775	-2,555	1,739,151	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	110,359	110,359	88.01
90.00	09000	CLINIC	153,482	51,971	-23,203	182,250	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,072,699	2,249,666	-57,668	3,264,697	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)	9,459,689	18,050,882	88,930	27,599,501	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	53,840	54,990	0	108,830	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	48,493	6,037	0	54,530	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	551,186	89,541	-88,930	551,797	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	10,113,208	18,201,450	0	28,314,658	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet A

Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-53,662	1,231,880	1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2	-71,299	827,592	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,067	687,867	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-87,710	2,496,442	4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	-23,597	2,445,076	5.01
5.02	00591	BUSINESS SERVICES	-66,113	670,430	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	935,798	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,653	8.00
9.00	00900	HOUSEKEEPING	-57	319,225	9.00
10.00	01000	DIETARY	-38,555	84,240	10.00
11.00	01100	CAFETERIA	-110,836	461,990	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	14.00
14.01	01401	PURCHASING	0	133,939	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	19,919	14.02
15.00	01500	PHARMACY	0	1,356,468	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	316,765	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-530,000	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-541,500	1,963,210	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-156,705	1,033,209	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20	989,749	54.00
57.00	05700	CT SCAN	0	175,376	57.00
58.00	05800	MRI	0	481,232	58.00
60.00	06000	LABORATORY	-3	1,760,643	60.00
65.00	06500	RESPIRATORY THERAPY	-50,045	510,392	65.00
66.00	06600	PHYSICAL THERAPY	0	494,540	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	157,327	67.00
68.00	06800	SPEECH PATHOLOGY	0	350	68.00
69.00	06900	ELECTROCARDIOLOGY	-34,202	40,412	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	403,677	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	338,429	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-7,853	-7,853	73.00
76.00	03550	BEHAVIORAL HEALTH	0	128,843	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,739,151	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	110,359	88.01
90.00	09000	CLINIC	0	182,250	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	90.01
91.00	09100	EMERGENCY	-1,012,497	2,252,200	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)	-2,786,721	24,812,780	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	108,830	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	54,530	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	551,797	192.02
192.03	19203	RISE OUTREACH LAB	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,786,721	25,527,937	200.00

RECLASSIFICATIONS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
8/27/2020 8:32 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS CAFETERIA COST				
1.00	CAFETERIA	11.00	234,184	338,642	1.00
	TOTALS		234,184	338,642	
	B - TO RECLASSIFY SUPPLY COST				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	417,309	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	417,309	
	C - TO RECLASS BUILDING DEPRECIATION				
1.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	560,585	1.00
2.00	STH FAM HLTH CRT	192.02	0	23,312	2.00
	TOTALS		0	583,897	
	F - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	233,550	1.00
2.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	310,313	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,607	3.00
	TOTALS		0	547,470	
	G - TO RECLASS OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	59,290	1.00
2.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	27,993	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	24,919	3.00
4.00	STH FAM HLTH CRT	192.02	0	1,244	4.00
	TOTALS		0	113,446	
	H - TO RECLASS FAMILY HEALTH CENTER COST				
1.00	RURAL HEALTH CLINIC II - FHCC	88.01	91,864	18,495	1.00
	TOTALS		91,864	18,495	
500.00	Grand Total: Increases		326,048	2,019,259	500.00

RECLASSIFICATIONS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-6

Date/Time Prepared:
8/27/2020 8:32 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS CAFETERIA COST						
1.00	DIETARY	10.00	234,184	338,642	0		1.00
	TOTALS		234,184	338,642			
	B - TO RECLASSIFY SUPPLY COST						
1.00	PHARMACY	15.00	0	86	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	24,346	0		2.00
3.00	OPERATING ROOM	50.00	0	216,279	0		3.00
4.00	OPERATING ROOM	50.00	0	8,554	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	70,533	0		5.00
6.00	CT SCAN	57.00	0	7,289	0		6.00
7.00	MRI	58.00	0	3,660	0		7.00
8.00	LABORATORY	60.00	0	3	0		8.00
9.00	PHYSICAL THERAPY	66.00	0	6	0		9.00
10.00	RURAL HEALTH CLINIC	88.00	0	2,555	0		10.00
11.00	CLINIC	90.00	0	23,203	0		11.00
12.00	EMERGENCY	91.00	0	57,668	0		12.00
13.00	STH FAM HLTH CRT	192.02	0	3,127	0		13.00
	TOTALS		0	417,309			
	C - TO RECLASS BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	583,897	9		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	583,897			
	F - TO RECLASS INTEREST EXPENSE						
1.00	ADMINISTRATIVE & ACCOUNTING	5.01	0	547,470	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	547,470			
	G - TO RECLASS OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & ACCOUNTING	5.01	0	113,446	14		1.00
2.00		0.00	0	0	14		2.00
3.00		0.00	0	0	14		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	113,446			
	H - TO RECLASS FAMILY HEALTH CENTER COST						
1.00	STH FAM HLTH CRT	192.02	91,864	18,495	0		1.00
	TOTALS		91,864	18,495			
500.00	Grand Total: Decreases		326,048	2,019,259			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part I
Date/Time Prepared:
8/27/2020 8:32 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	203,353	0	0	0	0	1.00	
2.00	Land Improvements	1,180,059	9,309	0	9,309	0	2.00	
3.00	Buildings and Fixtures	35,135,180	0	0	0	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	2,790,939	91,861	0	91,861	0	5.00	
6.00	Movable Equipment	10,026,436	851,698	0	851,698	853,024	6.00	
7.00	HIT designated Assets	1,079,269	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	50,415,236	952,868	0	952,868	853,024	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	50,415,236	952,868	0	952,868	853,024	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	203,353	0				1.00	
2.00	Land Improvements	1,189,368	0				2.00	
3.00	Buildings and Fixtures	35,135,180	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	2,882,800	0				5.00	
6.00	Movable Equipment	10,025,110	0				6.00	
7.00	HIT designated Assets	1,079,269	0				7.00	
8.00	Subtotal (sum of lines 1-7)	50,515,080	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	50,515,080	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part II
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,576,599	0	0	0	0	1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	661,408	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,238,007	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,576,599				1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	661,408				2.00
3.00	Total (sum of lines 1-2)	0	2,238,007				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet A-7
Part III
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	26,762,590	0	26,762,590	0.531935	0	1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	12,444,758	0	12,444,758	0.247353	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	11,104,379	0	11,104,379	0.220712	0	2.00
3.00	Total (sum of lines 1-2)	50,311,727	0	50,311,727	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	992,702	0	1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	0	0	0	560,585	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	660,170	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,213,457	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	179,888	0	0	59,290	1,231,880	1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	239,014	0	0	27,993	827,592	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2,778	0	0	24,919	687,867	2.00
3.00	Total (sum of lines 1-2)	421,680	0	0	112,202	2,747,339	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8

Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-53,662	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP-REL CSTS-BLDGS & FIX #2 (chapter 2)	B	-71,299	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	11	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-829	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,889	ADMINISTRATIVE & ACCOUNTING	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,866	ADMINISTRATIVE & ACCOUNTING	5.01	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,792,744			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-110,836	CAFETERIA	11.00	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 supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP-REL CSTS-BLDGS & FIX #2		0	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-530,000	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8

Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0 OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0 ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0 SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-1,238	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
34.00	DIETARY REVENUE	B	-38,555	DIETARY	10.00	0	34.00
35.00	BUS OFFICE COSTS ASSOC W/ PHYS	A	-37,908	BUSINESS SERVICES	5.02	0	35.00
37.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	37.00
39.00	LOBBYING PORTION OF DUES	A	-14,842	ADMINISTRATIVE & ACCOUNTING	5.01	0	39.00
40.00	MARKETING	A	-66,968	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	340B	B	-7,250	DRUGS CHARGED TO PATIENTS	73.00	0	41.00
42.00	SURGERY MISC REV	B	-2,205	OPERATING ROOM	50.00	0	42.00
43.00	PHARMACY MISC REV	B	-603	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
44.00	LAB MISC REV	B	-3	LABORATORY	60.00	0	44.00
45.00	RADIOLOGY MISC REV	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	45.00
46.00	HOUSEKEEPING MISC REV	B	-57	HOUSEKEEPING	9.00	0	46.00
47.00	OTHER MISC REV	B	-21	BUSINESS SERVICES	5.02	0	47.00
48.00	PROVIDER BENEFITS	A	-20,742	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
49.00	INT INCOME ON PAT ACCT	B	-28,184	BUSINESS SERVICES	5.02	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-2,786,721				50.00

(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 BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet A-8-2

Date/Time Prepared:
8/27/2020 8:32 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	541,500	541,500	0	0	0	1.00
2.00	50.00	OPERATING ROOM	154,500	154,500	0	0	0	2.00
3.00	50.00	OPERATING ROOM	24,000	0	24,000	0	0	3.00
4.00	60.00	LABORATORY	92,501	0	92,501	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	50,045	50,045	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	34,202	34,202	0	0	0	6.00
7.00	76.00	BEHAVIORAL HEALTH	9,000	0	9,000	0	0	7.00
8.00	91.00	EMERGENCY	2,046,689	1,012,497	1,034,192	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,952,437	1,792,744	1,159,693		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	76.00	BEHAVIORAL HEALTH	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	541,500		1.00
2.00	50.00	OPERATING ROOM	0	0	0	154,500		2.00
3.00	50.00	OPERATING ROOM	0	0	0	0		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	50,045		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	34,202		6.00
7.00	76.00	BEHAVIORAL HEALTH	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	1,012,497		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,792,744		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 8:32 am		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						52	1.00
2.00	Line 1 multiplied by 15 hours per week						780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						365	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)						0	6.00
7.00	Standard travel expense rate						5.79	7.00
8.00	Optional travel expense rate per mile						0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees		
		1.00	2.00	3.00	4.00	5.00		
9.00	Total hours worked	2,051.25	3,286.79	6,032.55	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	54.35	84.93	63.70	0.00	0.00	10.00	
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	42.47	42.47	31.85			11.00	
12.00	Number of travel hours (provider site)	0	0	0			12.00	
12.01	Number of travel hours (offsite)	0	0	0			12.01	
13.00	Number of miles driven (provider site)	0	0	0			13.00	
13.01	Number of miles driven (offsite)	0	0	0			13.01	
							1.00	
Part II - SALARY EQUIVALENCY COMPUTATION								
14.00	Supervisors (column 1, line 9 times column 1, line 10)						111,485	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						279,147	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						384,273	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						774,905	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)						0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)						0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)						774,905	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.								
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)						0	22.00
23.00	Total salary equivalency (see instructions)						774,905	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE								
Standard Travel Allowance								
24.00	Therapists (line 3 times column 2, line 11)						15,502	24.00
25.00	Assistants (line 4 times column 3, line 11)						0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)						15,502	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)						2,113	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						17,615	28.00
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)						0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)						0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)						0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)						17,615	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)						0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER 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)						0	37.00
38.00	Subtotal (sum of lines 36 and 37)						0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)						0	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)						0	41.00
42.00	Subtotal (sum of lines 40 and 41)						0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)						0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 8:32 am		
				Physical Therapy		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
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 column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
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	0.00	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	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	84.93	63.70	0.00	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 line 47 times line 52)	0	0	0	0		55.00	
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 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								
57.00	Salary equivalency amount (from line 23)						774,905	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						17,615	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						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	62.00
63.00	Total allowance (sum of lines 57-62)						792,520	63.00
64.00	Total cost of outside supplier services (from your records)						487,427	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						15,502	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,113	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						17,615	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						2,113	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						2,113	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 8:32 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					90	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.79	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,394.50	713.75	1,611.90	0.00	0.00	9.00
10.00	AHSEA (see instructions)	51.52	80.51	60.38	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40.26	40.26	30.19			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					71,845	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					57,464	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					97,327	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					226,636	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					226,636	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					226,636	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					3,623	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					3,623	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					521	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					4,144	28.00
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)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					4,144	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER 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)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	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)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 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

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				Occupational Therapy		Cost		
						1.00		
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
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 column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00	
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	0.00	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	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	80.51	60.38	0.00	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 line 47 times line 52)	0	0	0	0		55.00	
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 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								
57.00	Salary equivalency amount (from line 23)						226,636	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						4,144	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						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	62.00
63.00	Total allowance (sum of lines 57-62)						230,780	63.00
64.00	Total cost of outside supplier services (from your records)						155,117	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						3,623	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						521	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						4,144	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						521	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						521	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/27/2020 8:32 am	
				Speech Pathology		Cost	
				1.00			
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					4	1.00
2.00	Line 1 multiplied by 15 hours per week					60	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					4	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.79	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	7.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.36	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.68	38.68	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			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)					542	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					542	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					542	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					77.43	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					4,646	22.00
23.00	Total salary equivalency (see instructions)					4,646	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					155	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					155	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					23	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					178	28.00
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)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					178	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER 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)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	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)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 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

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				Speech Pathology		Cost		
						1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00	
		Therapists	Assistants	Aides	Trainees	Total		
		1.00	2.00	3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION								
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 column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	49.00	
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	0.00	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	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE								
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.36	0.00	0.00	0.00	0.00	52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0	0	53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0	0	54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0	0	55.00	
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 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								
57.00	Salary equivalency amount (from line 23)						4,646	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						178	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						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	62.00
63.00	Total allowance (sum of lines 57-62)						4,824	63.00
64.00	Total cost of outside supplier services (from your records)						350	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00
LINE 33 CALCULATION								
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						155	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						23	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						178	100.02
LINE 34 CALCULATION								
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						23	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01
101.02	Line 34 = sum of lines 27 and 31						23	101.02
LINE 35 CALCULATION								
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01
102.02	Line 35 = sum of lines 31 and 32						0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	NEW CAP-REL CSTS-BLDGS & FIX #2	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,231,880	1,231,880			1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2	827,592	0	827,592		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	687,867		687,867		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,496,442	12,741	2,100	2,511,283	4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	2,445,076	299,807	45,839	151,724	198,583
5.02	00591	BUSINESS SERVICES	670,430	30,758	0	2,169	107,034
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	935,798	326,192	40,018	21,987	74,405
8.00	00800	LAUNDRY & LINEN SERVICE	71,653	10,180	0		13,003
9.00	00900	HOUSEKEEPING	319,225	8,458	0	0	59,261
10.00	01000	DIETARY	84,240	27,189	0	9,088	12,786
11.00	01100	CAFETERIA	461,990	14,634	0	0	59,646
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
14.01	01401	PURCHASING	133,939	15,208	0	0	26,376
14.02	01402	CENTRAL SERVICES & SUPPLY	19,919	0	16,128	0	4,734
15.00	01500	PHARMACY	1,356,468	0	27,721	424	13,341
16.00	01600	MEDICAL RECORDS & LIBRARY	316,765	15,658	0	2,165	60,842
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,963,210	1,598	391,495	69,440	441,585
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,033,209	95,658	0	63,411	145,269
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	989,749	84,515	0	155,748	144,880
57.00	05700	CT SCAN	175,376	7,185	0	97,045	21,251
58.00	05800	MRI	481,232	5,230	0	0	19,866
60.00	06000	LABORATORY	1,760,643	55,945	0	31,147	158,382
65.00	06500	RESPIRATORY THERAPY	510,392	28,415	37,738	20,596	92,349
66.00	06600	PHYSICAL THERAPY	494,540	68,112	0	2,584	0
67.00	06700	OCCUPATIONAL THERAPY	157,327	11,080	0	0	0
68.00	06800	SPEECH PATHOLOGY	350	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	40,412	0	0	5,338	7,296
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	403,677	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	338,429	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-7,853	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	128,843	0	6,403	0	20,286
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,739,151	0	97,474	4,317	352,483
88.01	08801	RURAL HEALTH CLINIC II - FHCC	110,359	0	0	413	23,397
90.00	09000	CLINIC	182,250	35,134	5,918	1,249	39,091
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,252,200	65,008	0	32,217	272,085
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,812,780	1,218,705	668,734	673,162	2,368,231
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	108,830	13,175	0	3,071	13,713
192.00	19200	PHYSICIANS PRIVATE OFFICES	54,530	0	158,858	9,569	12,351
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	551,797	0	0	2,065	116,988
192.03	19203	RISE OUTREACH LAB	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	25,527,937	1,231,880	827,592	687,867	2,511,283

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
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Cost Center Description			Subtotal	ADMINISTRATIVE & ACCOUNTING	BUSINESS SERVICES	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			4A	5.01	5.02	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	3,141,029	3,141,029				5.01
5.02	00591	BUSINESS SERVICES	810,391	113,663	924,054			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	1,398,400	196,135	0	0	1,594,535	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,836	13,301	0	0	14,868	8.00
9.00	00900	HOUSEKEEPING	386,944	54,272	0	0	12,352	9.00
10.00	01000	DIETARY	133,303	18,697	0	0	39,709	10.00
11.00	01100	CAFETERIA	536,270	75,216	0	0	21,373	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	175,523	24,618	0	0	22,212	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	40,781	5,720	0	0	15,072	14.02
15.00	01500	PHARMACY	1,397,954	196,073	0	0	25,906	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	395,430	55,462	0	0	22,869	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,867,328	402,171	136,276	0	368,195	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,337,547	187,600	42,003	0	139,708	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,374,892	192,838	98,962	0	123,434	54.00
57.00	05700	CT SCAN	300,857	42,197	142,698	0	10,494	57.00
58.00	05800	MRI	506,328	71,016	25,889	0	7,638	58.00
60.00	06000	LABORATORY	2,006,117	281,372	190,492	0	81,708	60.00
65.00	06500	RESPIRATORY THERAPY	689,490	96,706	54,813	0	76,767	65.00
66.00	06600	PHYSICAL THERAPY	565,236	79,278	30,318	0	99,477	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,407	23,620	6,553	0	16,183	67.00
68.00	06800	SPEECH PATHOLOGY	350	49	16	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	53,046	7,440	14,894	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	403,677	56,619	13,971	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	338,429	47,467	8,112	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-7,853	0	28,770	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	155,532	21,814	324	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,193,425	307,643	27,650	0	91,091	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	134,169	18,818	2,155	0	13,690	88.01
90.00	09000	CLINIC	263,642	36,978	7,479	0	60,697	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,621,510	367,685	92,679	0	94,944	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	24,482,990	2,994,468	924,054	0	1,358,387	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	138,789	19,466	0	0	19,243	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	235,308	33,004	0	0	148,456	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	670,850	94,091	0	0	68,449	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	25,527,937	3,141,029	924,054	0	1,594,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
			8.00	9.00	10.00	11.00	12.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	00591	BUSINESS SERVICES						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	123,005					8.00
9.00	00900	HOUSEKEEPING	17,776	471,344				9.00
10.00	01000	DIETARY	3,354	23,498	218,561			10.00
11.00	01100	CAFETERIA	0	0	0	632,859		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	10,685	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	7,257	0	3,284	0	14.02
15.00	01500	PHARMACY	0	7,602	0	8,652	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,220	0	31,690	0	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	49,344	140,297	218,561	159,907	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,664	38,357	0	49,672	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,042	33,174	0	53,477	0	54.00
57.00	05700	CT SCAN	0	6,220	0	7,141	0	57.00
58.00	05800	MRI	0	3,456	0	7,558	0	58.00
60.00	06000	LABORATORY	0	32,828	0	72,449	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	11,749	0	38,205	0	65.00
66.00	06600	PHYSICAL THERAPY	5,544	9,676	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,419	0	3,284	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	BEHAVIORAL HEALTH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	28,681	0	74,638	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	691	0	0	0	88.01
90.00	09000	CLINIC	0	17,278	0	12,978	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	17,281	58,054	0	84,697	0	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)	123,005	427,457	218,561	618,317	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	13,477	0	9,851	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	26,954	0	4,691	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	3,456	0	0	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	123,005	471,344	218,561	632,859	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	
			13.00	14.00	14.01	14.02	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	00591	BUSINESS SERVICES						5.02
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
14.01	01401	PURCHASING	0	0	233,038			14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	0	72,114		14.02
15.00	01500	PHARMACY	0	0	0	0	1,636,187	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	146	0	0	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	5,911	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	20,418	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,757	0	0	54.00
57.00	05700	CT SCAN	0	0	2,130	0	0	57.00
58.00	05800	MRI	0	0	146	0	0	58.00
60.00	06000	LABORATORY	0	0	91,626	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,753	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	488	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	134	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	356	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	52,357	39,227	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	43,894	32,887	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,636,187	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	568	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	2,165	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	177	0	0	88.01
90.00	09000	CLINIC	0	0	557	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	5,768	0	0	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)	0	0	231,351	72,114	1,636,187	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	688	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	115	0	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	884	0	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	233,038	72,114	1,636,187	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	00591	BUSINESS SERVICES						5.02
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
14.01	01401	PURCHASING						14.01
14.02	01402	CENTRAL SERVICES & SUPPLY						14.02
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	511,817					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54,575	0	0	4,402,565	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,340	0	0	1,856,309	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	62,060	0	0	1,955,636	0	54.00
57.00	05700	CT SCAN	89,485	0	0	601,222	0	57.00
58.00	05800	MRI	16,234	0	0	638,265	0	58.00
60.00	06000	LABORATORY	119,441	0	0	2,876,033	0	60.00
65.00	06500	RESPIRATORY THERAPY	34,374	0	0	1,004,857	0	65.00
66.00	06600	PHYSICAL THERAPY	19,013	0	0	809,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,109	0	0	219,006	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	415	0	68.00
69.00	06900	ELECTROCARDIOLOGY	9,340	0	0	90,779	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	565,851	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	470,789	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,657,104	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	178,238	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	17,339	0	0	2,742,632	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	1,352	0	0	171,052	0	88.01
90.00	09000	CLINIC	4,892	0	0	404,501	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	53,263	0	0	3,395,881	0	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)	511,817	0	0	24,040,165	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	201,514	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	448,528	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	0	837,730	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	511,817	0	0	25,527,937	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet B
Part I
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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	5.01
5.02	00591	BUSINESS SERVICES	5.02
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	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
14.01	01401	PURCHASING	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	14.02
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
		4,402,565	
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
76.00	03550	BEHAVIORAL HEALTH	76.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	88.01
90.00	09000	CLINIC	90.00
90.01	09001	SALEM MEDICAL CLINIC	90.01
91.00	09100	EMERGENCY	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)	118.00
		24,040,165	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	192.00
192.01	19201	TEMPORARILY IDLE SPACE	192.01
192.02	19202	STH FAM HLTH CRT	192.02
192.03	19203	RISE OUTREACH LAB	192.03
194.00	07950	LITIGATION COSTS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00
		25,527,937	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
			BLDG & FIXT	NEW CAP-REL CSTS-BLDGS & FIX #2	MVBLE EQUIP		
		0	1.00	1.01	2.00	2A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,741	0	2,100	4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	0	299,807	45,839	151,724	5.01
5.02	00591	BUSINESS SERVICES	0	30,758	0	2,169	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	326,192	40,018	21,987	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,180	0	0	8.00
9.00	00900	HOUSEKEEPING	0	8,458	0	0	9.00
10.00	01000	DIETARY	0	27,189	0	9,088	10.00
11.00	01100	CAFETERIA	0	14,634	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
14.01	01401	PURCHASING	0	15,208	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	16,128	0	14.02
15.00	01500	PHARMACY	0	0	27,721	424	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,658	0	2,165	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,598	391,495	69,440	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	95,658	0	63,411	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,515	0	155,748	54.00
57.00	05700	CT SCAN	0	7,185	0	97,045	57.00
58.00	05800	MRI	0	5,230	0	0	58.00
60.00	06000	LABORATORY	0	55,945	0	31,147	60.00
65.00	06500	RESPIRATORY THERAPY	0	28,415	37,738	20,596	65.00
66.00	06600	PHYSICAL THERAPY	0	68,112	0	2,584	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,080	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,338	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	6,403	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	97,474	4,317	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	0	413	88.01
90.00	09000	CLINIC	0	35,134	5,918	1,249	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	65,008	0	32,217	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)	0	1,218,705	668,734	673,162	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	13,175	0	3,071	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	158,858	9,569	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	0	2,065	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,231,880	827,592	687,867	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & ACCOUNTING	BUSINESS SERVICES	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
			4.00	5.01	5.02	6.00	7.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,841					4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	1,173	498,543				5.01
5.02	00591	BUSINESS SERVICES	632	18,041	51,600			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	440	31,131	0	0	419,768	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	77	2,111	0	0	3,914	8.00
9.00	00900	HOUSEKEEPING	350	8,614	0	0	3,252	9.00
10.00	01000	DIETARY	76	2,968	0	0	10,454	10.00
11.00	01100	CAFETERIA	352	11,938	0	0	5,627	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	156	3,907	0	0	5,847	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	28	908	0	0	3,968	14.02
15.00	01500	PHARMACY	79	31,121	0	0	6,820	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	360	8,803	0	0	6,020	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,611	63,826	7,610	0	96,927	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	858	29,776	2,346	0	36,779	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	856	30,608	5,526	0	32,495	54.00
57.00	05700	CT SCAN	126	6,698	7,968	0	2,763	57.00
58.00	05800	MRI	117	11,272	1,446	0	2,011	58.00
60.00	06000	LABORATORY	936	44,660	10,636	0	21,510	60.00
65.00	06500	RESPIRATORY THERAPY	546	15,349	3,061	0	20,209	65.00
66.00	06600	PHYSICAL THERAPY	0	12,583	1,693	0	26,188	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,749	366	0	4,260	67.00
68.00	06800	SPEECH PATHOLOGY	0	8	1	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	43	1,181	832	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,987	780	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,534	453	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,607	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	120	3,462	18	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,083	48,830	1,544	0	23,980	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	138	2,987	120	0	3,604	88.01
90.00	09000	CLINIC	231	5,869	418	0	15,979	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,608	58,360	5,175	0	24,994	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)	13,996	475,281	51,600	0	357,601	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	81	3,090	0	0	5,066	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	73	5,238	0	0	39,082	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	691	14,934	0	0	18,019	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,841	498,543	51,600	0	419,768	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet B
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Cost Center Description			LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	
			8.00	9.00	10.00	11.00	12.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	00591	BUSINESS SERVICES						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	16,282					8.00
9.00	00900	HOUSEKEEPING	2,353	23,027				9.00
10.00	01000	DIETARY	444	1,148	51,367			10.00
11.00	01100	CAFETERIA	0	0	0	32,551		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	0	550	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	355	0	169	0	14.02
15.00	01500	PHARMACY	0	371	0	445	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	304	0	1,630	0	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,531	6,853	51,367	8,224	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,941	1,874	0	2,555	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,991	1,621	0	2,751	0	54.00
57.00	05700	CT SCAN	0	304	0	367	0	57.00
58.00	05800	MRI	0	169	0	389	0	58.00
60.00	06000	LABORATORY	0	1,604	0	3,726	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	574	0	1,965	0	65.00
66.00	06600	PHYSICAL THERAPY	734	473	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	118	0	169	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	BEHAVIORAL HEALTH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,401	0	3,839	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	34	0	0	0	88.01
90.00	09000	CLINIC	0	844	0	668	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,288	2,836	0	4,356	0	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)	16,282	20,883	51,367	31,803	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	658	0	507	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	1,317	0	241	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	169	0	0	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,282	23,027	51,367	32,551	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

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Cost Center Description			NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY	PURCHASING	CENTRAL SERVICES & SUPPLY	PHARMACY	
			13.00	14.00	14.01	14.02	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	00591	BUSINESS SERVICES						5.02
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION	0					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
14.01	01401	PURCHASING	0	0	25,668			14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	0	21,556		14.02
15.00	01500	PHARMACY	0	0	0	0	66,981	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16	0	0	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	651	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	2,249	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	193	0	0	54.00
57.00	05700	CT SCAN	0	0	235	0	0	57.00
58.00	05800	MRI	0	0	16	0	0	58.00
60.00	06000	LABORATORY	0	0	10,093	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	303	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	54	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	15	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	39	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,767	11,726	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,835	9,830	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	66,981	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	63	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	238	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	19	0	0	88.01
90.00	09000	CLINIC	0	0	61	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	635	0	0	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)	0	0	25,482	21,556	66,981	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	76	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	13	0	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	97	0	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	0	25,668	21,556	66,981	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
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Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	00591	BUSINESS SERVICES						5.02
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
14.01	01401	PURCHASING						14.01
14.02	01402	CENTRAL SERVICES & SUPPLY						14.02
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	34,956					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,727	0		710,860	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,799	0		239,246	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,239	0		320,543	0	54.00
57.00	05700	CT SCAN	6,112	0		128,803	0	57.00
58.00	05800	MRI	1,109	0		21,759	0	58.00
60.00	06000	LABORATORY	8,156	0		188,413	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,348	0		131,104	0	65.00
66.00	06600	PHYSICAL THERAPY	1,299	0		113,720	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	0		19,751	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		9	0	68.00
69.00	06900	ELECTROCARDIOLOGY	638	0		8,358	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		27,260	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		22,652	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		68,588	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0		10,066	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,184	0		184,890	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	92	0		7,407	0	88.01
90.00	09000	CLINIC	334	0		66,705	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		0	0	90.01
91.00	09100	EMERGENCY	3,638	0		201,115	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,956	0	0	2,471,249	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		25,724	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		214,391	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0		0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0		35,975	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0		0	0	192.03
194.00	07950	LITIGATION COSTS	0	0		0	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,956	0	0	2,747,339	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING		5.01
5.02	00591	BUSINESS SERVICES		5.02
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	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
14.01	01401	PURCHASING		14.01
14.02	01402	CENTRAL SERVICES & SUPPLY		14.02
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	710,860	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	239,246	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	320,543	54.00
57.00	05700	CT SCAN	128,803	57.00
58.00	05800	MRI	21,759	58.00
60.00	06000	LABORATORY	188,413	60.00
65.00	06500	RESPIRATORY THERAPY	131,104	65.00
66.00	06600	PHYSICAL THERAPY	113,720	66.00
67.00	06700	OCCUPATIONAL THERAPY	19,751	67.00
68.00	06800	SPEECH PATHOLOGY	9	68.00
69.00	06900	ELECTROCARDIOLOGY	8,358	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,652	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	68,588	73.00
76.00	03550	BEHAVIORAL HEALTH	10,066	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	184,890	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	7,407	88.01
90.00	09000	CLINIC	66,705	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	90.01
91.00	09100	EMERGENCY	201,115	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)		2,471,249	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	25,724	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	214,391	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	192.01
192.02	19202	STH FAM HLTH CRT	35,975	192.02
192.03	19203	RISE OUTREACH LAB	0	192.03
194.00	07950	LITIGATION COSTS	0	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,747,339	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

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Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	NEW CAP-REL CSTS-BLDGS & FIX #2 (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,380					1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2	0	34,123				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			661,410			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	821	0	2,019	9,859,868		4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	19,319	1,890	145,888	779,685	-3,141,029	5.00
5.02	00591	BUSINESS SERVICES	1,982	0	2,086	420,241	0	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	21,019	1,650	21,141	292,130	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	656	0	0	51,053	0	8.00
9.00	00900	HOUSEKEEPING	545	0	0	232,671	0	9.00
10.00	01000	DIETARY	1,752	0	8,738	50,201	0	10.00
11.00	01100	CAFETERIA	943	0	0	234,184	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	980	0	0	103,558	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	665	0	18,586	0	14.02
15.00	01500	PHARMACY	0	1,143	408	52,381	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,009	0	2,082	238,880	0	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	103	16,142	66,769	1,733,743	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,164	0	60,972	570,359	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,446	0	149,757	568,832	0	54.00
57.00	05700	CT SCAN	463	0	93,312	83,438	0	57.00
58.00	05800	MRI	337	0	0	78,000	0	58.00
60.00	06000	LABORATORY	3,605	0	29,949	621,844	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,831	1,556	19,804	362,585	0	65.00
66.00	06600	PHYSICAL THERAPY	4,389	0	2,485	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	714	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	5,133	28,646	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	7,853	73.00
76.00	03550	BEHAVIORAL HEALTH	0	264	0	79,649	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	4,019	4,151	1,383,931	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	397	91,864	0	88.01
90.00	09000	CLINIC	2,264	244	1,201	153,482	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,189	0	30,978	1,068,270	0	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)	78,531	27,573	647,270	9,298,213	-3,133,176	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	849	0	2,953	53,840	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,550	9,201	48,493	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	1,986	459,322	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,231,880	827,592	687,867	2,511,283		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.518770	24.253202	1.040001	0.254697		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				14,841		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001505		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE & ACCOUNTING (ACCUM. COST)	BUSINESS SERVICES (GROSS CHARGES)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	
		5.01	5.02	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	22,394,761	79,261,359			5.01
5.02	00591	BUSINESS SERVICES	810,391				5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	1,398,400	0	0	70,352	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	94,836	0	0	656	12,691 8.00
9.00	00900	HOUSEKEEPING	386,944	0	0	545	1,834 9.00
10.00	01000	DIETARY	133,303	0	0	1,752	346 10.00
11.00	01100	CAFETERIA	536,270	0	0	943	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0 14.00
14.01	01401	PURCHASING	175,523	0	0	980	0 14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	40,781	0	0	665	0 14.02
15.00	01500	PHARMACY	1,397,954	0	0	1,143	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	395,430	0	0	1,009	0 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
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,867,328	11,689,512	0	16,245	5,091 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,337,547	3,602,957	0	6,164	1,513 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,374,892	8,488,736	0	5,446	1,552 54.00
57.00	05700	CT SCAN	300,857	12,240,318	0	463	0 57.00
58.00	05800	MRI	506,328	2,220,714	0	337	0 58.00
60.00	06000	LABORATORY	2,006,117	16,337,969	0	3,605	0 60.00
65.00	06500	RESPIRATORY THERAPY	689,490	4,701,711	0	3,387	0 65.00
66.00	06600	PHYSICAL THERAPY	565,236	2,600,653	0	4,389	572 66.00
67.00	06700	OCCUPATIONAL THERAPY	168,407	562,065	0	714	0 67.00
68.00	06800	SPEECH PATHOLOGY	350	1,356	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	53,046	1,277,583	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	403,677	1,198,413	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	338,429	695,859	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,467,849	0	0	0 73.00
76.00	03550	BEHAVIORAL HEALTH	155,532	27,805	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,193,425	2,371,751	0	4,019	0 88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	134,169	184,816	0	604	0 88.01
90.00	09000	CLINIC	263,642	641,507	0	2,678	0 90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0 90.01
91.00	09100	EMERGENCY	2,621,510	7,949,785	0	4,189	1,783 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)	21,349,814	79,261,359	0	59,933	12,691 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	138,789	0	0	849	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	235,308	0	0	6,550	0 192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0 192.01
192.02	19202	STH FAM HLTH CRT	670,850	0	0	3,020	0 192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0 192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,141,029	924,054	0	1,594,535	123,005 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.140257	0.011658	0.000000	22.665098	9.692302 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	498,543	51,600	0	419,768	16,282 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.022262	0.000651	0.000000	5.966682	1.282956 205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (DIRECT NRSING HRS)	
			9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	00591	BUSINESS SERVICES						5.02
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	HOUSEKEEPING	1,364					9.00
10.00	01000	DIETARY	68	7,933				10.00
11.00	01100	CAFETERIA	0	0	12,142			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	166,589	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	205	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	21	0	63	0	0	14.02
15.00	01500	PHARMACY	22	0	166	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18	0	608	0	0	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	406	7,933	3,068	0	69,591	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	111	0	953	0	33,403	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96	0	1,026	0	0	54.00
57.00	05700	CT SCAN	18	0	137	0	0	57.00
58.00	05800	MRI	10	0	145	0	0	58.00
60.00	06000	LABORATORY	95	0	1,390	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	34	0	733	0	0	65.00
66.00	06600	PHYSICAL THERAPY	28	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	7	0	63	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	BEHAVIORAL HEALTH	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	83	0	1,432	0	29,797	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	2	0	0	0	0	88.01
90.00	09000	CLINIC	50	0	249	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	168	0	1,625	0	33,798	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)	1,237	7,933	11,863	0	166,589	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	39	0	189	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	78	0	90	0	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	10	0	0	0	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	471,344	218,561	632,859	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	345.560117	27.550863	52.121479	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,027	51,367	32,551	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	16.881965	6.475104	2.680860	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PURCHASING (COSTED REQUIS.)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			14.00	14.01	14.02	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING						5.01
5.02	00591	BUSINESS SERVICES						5.02
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0					14.00
14.01	01401	PURCHASING	0	1,796,765				14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	742,108			14.02
15.00	01500	PHARMACY	0	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,123	0	0	181,001	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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	45,573	0	0	19,300	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	157,428	0	0	9,315	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,543	0	0	21,947	54.00
57.00	05700	CT SCAN	0	16,419	0	0	31,646	57.00
58.00	05800	MRI	0	1,125	0	0	5,741	58.00
60.00	06000	LABORATORY	0	706,469	0	0	42,240	60.00
65.00	06500	RESPIRATORY THERAPY	0	21,228	0	0	12,156	65.00
66.00	06600	PHYSICAL THERAPY	0	3,759	0	0	6,724	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,032	0	0	1,453	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,743	0	0	3,303	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	403,679	403,679	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	338,429	338,429	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	4,378	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	16,692	0	0	6,132	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	1,363	0	0	478	88.01
90.00	09000	CLINIC	0	4,296	0	0	1,730	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	44,476	0	0	18,836	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)	0	1,783,755	742,108	100	181,001	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	5,308	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	887	0	0	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	6,815	0	0	0	192.02
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0	192.03
194.00	07950	LITIGATION COSTS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	233,038	72,114	1,636,187	511,817	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.129699	0.097175	16,361.870000	2.827703	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	25,668	21,556	66,981	34,956	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.014286	0.029047	669.810000	0.193126	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet B-1

Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		17.00	19.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING		5.01
5.02	00591	BUSINESS SERVICES		5.02
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	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
14.01	01401	PURCHASING		14.01
14.02	01402	CENTRAL SERVICES & SUPPLY		14.02
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	88.01
90.00	09000	CLINIC	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	90.01
91.00	09100	EMERGENCY	0	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)	0	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	192.01
192.02	19202	STH FAM HLTH CRT	0	192.02
192.03	19203	RISE OUTREACH LAB	0	192.03
194.00	07950	LITIGATION COSTS	0	194.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/27/2020 8:32 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,402,565		4,402,565	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,856,309		1,856,309	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,955,636		1,955,636	0	0	54.00
57.00	05700 CT SCAN	601,222		601,222	0	0	57.00
58.00	05800 MRI	638,265		638,265	0	0	58.00
60.00	06000 LABORATORY	2,876,033		2,876,033	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	1,004,857	0	1,004,857	0	0	65.00
66.00	06600 PHYSICAL THERAPY	809,030	0	809,030	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	219,006	0	219,006	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	415	0	415	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	90,779		90,779	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	565,851		565,851	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	470,789		470,789	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,657,104		1,657,104	0	0	73.00
76.00	03550 BEHAVIORAL HEALTH	178,238		178,238	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	2,742,632		2,742,632	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHCC	171,052		171,052	0	0	88.01
90.00	09000 CLINIC	404,501		404,501	0	0	90.00
90.01	09001 SALEM MEDICAL CLINIC	0		0	0	0	90.01
91.00	09100 EMERGENCY	3,395,881		3,395,881	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	351,192		351,192	0	0	92.00
200.00	Subtotal (see instructions)	24,391,357	0	24,391,357	0	0	200.00
201.00	Less Observation Beds	351,192		351,192	0	0	201.00
202.00	Total (see instructions)	24,040,165	0	24,040,165	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/27/2020 8:32 am

			Title XVIII		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,337,541		11,337,541		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	494,734	3,108,223	3,602,957	0.515218	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	457,339	8,031,397	8,488,736	0.230380	0.000000
57.00	05700	CT SCAN	628,531	11,611,787	12,240,318	0.049118	0.000000
58.00	05800	MRI	86,171	2,134,543	2,220,714	0.287414	0.000000
60.00	06000	LABORATORY	1,792,440	14,545,528	16,337,968	0.176034	0.000000
65.00	06500	RESPIRATORY THERAPY	2,477,768	2,223,943	4,701,711	0.213722	0.000000
66.00	06600	PHYSICAL THERAPY	475,783	2,124,870	2,600,653	0.311087	0.000000
67.00	06700	OCCUPATIONAL THERAPY	336,721	225,344	562,065	0.389645	0.000000
68.00	06800	SPEECH PATHOLOGY	1,356	0	1,356	0.306047	0.000000
69.00	06900	ELECTROCARDIOLOGY	44,341	1,233,241	1,277,582	0.071055	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	261,573	936,841	1,198,414	0.472167	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	465,208	230,651	695,859	0.676558	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	627,848	1,840,001	2,467,849	0.671477	0.000000
76.00	03550	BEHAVIORAL HEALTH	0	27,805	27,805	6.410286	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,371,751	2,371,751		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	184,816	184,816		88.01
90.00	09000	CLINIC	10,376	631,131	641,507	0.630548	0.000000
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	1,930	7,947,856	7,949,786	0.427166	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	351,971	351,971	0.997787	0.000000
200.00		Subtotal (see instructions)	19,499,660	59,761,699	79,261,359		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,499,660	59,761,699	79,261,359		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	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	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550	BEHAVIORAL HEALTH	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC				88.01
90.00	09000	CLINIC	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/27/2020 8:32 am

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	4,402,565		4,402,565	0		0	30.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	1,856,309		1,856,309	0		0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,955,636		1,955,636	0		0	54.00
57.00	05700	CT SCAN	601,222		601,222	0		0	57.00
58.00	05800	MRI	638,265		638,265	0		0	58.00
60.00	06000	LABORATORY	2,876,033		2,876,033	0		0	60.00
65.00	06500	RESPIRATORY THERAPY	1,004,857	0	1,004,857	0		0	65.00
66.00	06600	PHYSICAL THERAPY	809,030	0	809,030	0		0	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,006	0	219,006	0		0	67.00
68.00	06800	SPEECH PATHOLOGY	415	0	415	0		0	68.00
69.00	06900	ELECTROCARDIOLOGY	90,779		90,779	0		0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	565,851		565,851	0		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	470,789		470,789	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,657,104		1,657,104	0		0	73.00
76.00	03550	BEHAVIORAL HEALTH	178,238		178,238	0		0	76.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	2,742,632		2,742,632	0		0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	171,052		171,052	0		0	88.01
90.00	09000	CLINIC	404,501		404,501	0		0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0		0	0		0	90.01
91.00	09100	EMERGENCY	3,395,881		3,395,881	0		0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	351,192		351,192	0		0	92.00
200.00		Subtotal (see instructions)	24,391,357	0	24,391,357	0		0	200.00
201.00		Less Observation Beds	351,192		351,192	0		0	201.00
202.00		Total (see instructions)	24,040,165	0	24,040,165	0		0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
8/27/2020 8:32 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	11,337,541		11,337,541		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	494,734	3,108,223	3,602,957	0.515218	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	457,339	8,031,397	8,488,736	0.230380	0.000000
57.00	05700	CT SCAN	628,531	11,611,787	12,240,318	0.049118	0.000000
58.00	05800	MRI	86,171	2,134,543	2,220,714	0.287414	0.000000
60.00	06000	LABORATORY	1,792,440	14,545,528	16,337,968	0.176034	0.000000
65.00	06500	RESPIRATORY THERAPY	2,477,768	2,223,943	4,701,711	0.213722	0.000000
66.00	06600	PHYSICAL THERAPY	475,783	2,124,870	2,600,653	0.311087	0.000000
67.00	06700	OCCUPATIONAL THERAPY	336,721	225,344	562,065	0.389645	0.000000
68.00	06800	SPEECH PATHOLOGY	1,356	0	1,356	0.306047	0.000000
69.00	06900	ELECTROCARDIOLOGY	44,341	1,233,241	1,277,582	0.071055	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	261,573	936,841	1,198,414	0.472167	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	465,208	230,651	695,859	0.676558	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	627,848	1,840,001	2,467,849	0.671477	0.000000
76.00	03550	BEHAVIORAL HEALTH	0	27,805	27,805	6.410286	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,371,751	2,371,751	1.156374	0.000000
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	184,816	184,816	0.925526	0.000000
90.00	09000	CLINIC	10,376	631,131	641,507	0.630548	0.000000
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	1,930	7,947,856	7,949,786	0.427166	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	351,971	351,971	0.997787	0.000000
200.00		Subtotal (see instructions)	19,499,660	59,761,699	79,261,359		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	19,499,660	59,761,699	79,261,359		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	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	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
76.00	03550	BEHAVIORAL HEALTH	0.000000			76.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0.000000			88.01
90.00	09000	CLINIC	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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part II
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			Title XVIII		Hospital	Cost	
			Capital Related Cost (from Wkst. C, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	239,246	3,602,957	0.066403	276,820	18,382
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	320,543	8,488,736	0.037761	275,741	10,412
57.00	05700	CT SCAN	128,803	12,240,318	0.010523	438,594	4,615
58.00	05800	MRI	21,759	2,220,714	0.009798	78,498	769
60.00	06000	LABORATORY	188,413	16,337,968	0.011532	1,050,919	12,119
65.00	06500	RESPIRATORY THERAPY	131,104	4,701,711	0.027884	1,456,916	40,625
66.00	06600	PHYSICAL THERAPY	113,720	2,600,653	0.043727	53,629	2,345
67.00	06700	OCCUPATIONAL THERAPY	19,751	562,065	0.035140	27,058	951
68.00	06800	SPEECH PATHOLOGY	9	1,356	0.006637	1,017	7
69.00	06900	ELECTROCARDIOLOGY	8,358	1,277,582	0.006542	27,358	179
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,260	1,198,414	0.022747	171,695	3,906
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,652	695,859	0.032553	279,714	9,106
73.00	07300	DRUGS CHARGED TO PATIENTS	68,588	2,467,849	0.027793	326,365	9,071
76.00	03550	BEHAVIORAL HEALTH	10,066	27,805	0.362021	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	184,890	2,371,751	0.077955	0	0
88.01	08801	RURAL HEALTH CLINIC II - FHCC	7,407	184,816	0.040078	0	0
90.00	09000	CLINIC	66,705	641,507	0.103982	5,160	537
90.01	09001	SALEM MEDICAL CLINIC	0	0	0.000000	0	0
91.00	09100	EMERGENCY	201,115	7,949,786	0.025298	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	56,705	351,971	0.161107	0	0
200.00		Total (lines 50 through 199)	1,817,094	67,923,818		4,469,484	113,024

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			Title XVIII		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	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	BEHAVIORAL HEALTH	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	0	0	0 88.01
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0 90.01
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			Title XVIII		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,602,957	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,488,736	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	12,240,318	0.000000	57.00
58.00	05800	MRI	0	0	0	2,220,714	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	16,337,968	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,701,711	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,600,653	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	562,065	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,356	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,277,582	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,198,414	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	695,859	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,467,849	0.000000	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	27,805	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,371,751	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	0	184,816	0.000000	88.01
90.00	09000	CLINIC	0	0	0	641,507	0.000000	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	7,949,786	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	351,971	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	67,923,818		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			Title XVIII		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	276,820	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	275,741	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	438,594	0	0	0	57.00
58.00	05800	MRI	0.000000	78,498	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,050,919	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,456,916	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	53,629	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	27,058	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,017	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	27,358	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	171,695	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	279,714	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	326,365	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	5,160	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)		4,469,484	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/27/2020 8:32 am

				Title XVIII		Hospital		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.515218	0	1,614,764	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230380	0	3,314,906	0	0	54.00	
57.00	05700	CT SCAN	0.049118	0	4,860,910	0	0	57.00	
58.00	05800	MRI	0.287414	0	782,578	0	0	58.00	
60.00	06000	LABORATORY	0.176034	0	5,366,548	4,981	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.213722	0	1,090,413	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.311087	0	729,193	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.389645	0	77,289	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.306047	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.071055	0	573,377	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.472167	0	333,752	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.676558	0	118,257	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.671477	0	1,037,164	0	0	73.00	
76.00	03550	BEHAVIORAL HEALTH	6.410286	0	13,685	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 - FHCC	0.000000				0	88.01	
90.00	09000	CLINIC	0.630548	0	375,465	0	0	90.00	
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0.427166	0	2,633,102	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.997787	0	128,830	0	0	92.00	
200.00		Subtotal (see instructions)		0	23,050,233	4,981	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		0	23,050,233	4,981	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/27/2020 8:32 am

				Title XVIII	Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	831,955	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	763,688	0		54.00
57.00	05700	CT SCAN	238,758	0		57.00
58.00	05800	MRI	224,924	0		58.00
60.00	06000	LABORATORY	944,695	877		60.00
65.00	06500	RESPIRATORY THERAPY	233,045	0		65.00
66.00	06600	PHYSICAL THERAPY	226,842	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	30,115	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	40,741	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,587	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,008	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	696,432	0		73.00
76.00	03550	BEHAVIORAL HEALTH	87,725	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0		88.01
90.00	09000	CLINIC	236,749	0		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	1,124,772	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	128,545	0		92.00
200.00		Subtotal (see instructions)	6,046,581	877		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	6,046,581	877		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1345

Period:

Worksheet D

Component CCN:14-Z345

From 04/01/2019

Part V

To 03/31/2020

Date/Time Prepared:

8/27/2020 8:32 am

			Title XVIII		Swing Beds - SNF		Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
					2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.515218	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230380	0	0	0	0	54.00
57.00	05700	CT SCAN	0.049118	0	0	0	0	57.00
58.00	05800	MRI	0.287414	0	0	0	0	58.00
60.00	06000	LABORATORY	0.176034	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.213722	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.311087	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.389645	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.306047	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071055	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.472167	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.676558	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.671477	0	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	6.410286	0	0	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 - FHCC	0.000000				0	88.01
90.00	09000	CLINIC	0.630548	0	0	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.427166	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.997787	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program			0	0		201.00
		Only Charges						
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-1345

Period:

Worksheet D

Component CCN:14-Z345

From 04/01/2019
To 03/31/2020Part V
Date/Time Prepared:
8/27/2020 8:32 am

				Title XVIII	Swing Beds - SNF	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	BEHAVIORAL HEALTH	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part I
Date/Time Prepared:
8/27/2020 8:32 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	710,860	279,750	431,110	1,741	247.62	30.00
200.00	Total (lines 30 through 199)	710,860		431,110	1,741		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	59	14,610				30.00
200.00	Total (lines 30 through 199)	59	14,610				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part II
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	239,246	3,602,957	0.066403	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	320,543	8,488,736	0.037761	0	0	54.00
57.00	05700 CT SCAN	128,803	12,240,318	0.010523	0	0	57.00
58.00	05800 MRI	21,759	2,220,714	0.009798	0	0	58.00
60.00	06000 LABORATORY	188,413	16,337,968	0.011532	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	131,104	4,701,711	0.027884	0	0	65.00
66.00	06600 PHYSICAL THERAPY	113,720	2,600,653	0.043727	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	19,751	562,065	0.035140	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	9	1,356	0.006637	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	8,358	1,277,582	0.006542	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27,260	1,198,414	0.022747	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	22,652	695,859	0.032553	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	68,588	2,467,849	0.027793	0	0	73.00
76.00	03550 BEHAVIORAL HEALTH	10,066	27,805	0.362021	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	184,890	2,371,751	0.077955	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHCC	7,407	184,816	0.040078	0	0	88.01
90.00	09000 CLINIC	66,705	641,507	0.103982	0	0	90.00
90.01	09001 SALEM MEDICAL CLINIC	0	0	0.000000	0	0	90.01
91.00	09100 EMERGENCY	201,115	7,949,786	0.025298	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	56,705	351,971	0.161107	0	0	92.00
200.00	Total (lines 50 through 199)	1,817,094	67,923,818		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-1345		Period: From 04/01/2019 To 03/31/2020		Worksheet D Part III Date/Time Prepared: 8/27/2020 8:32 am		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	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 Patient Days	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 & PEDIATRICS	0	0	1,741	0.00	59	30.00			
200.00		Total (lines 30 through 199)	0	0	1,741		59	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	0							30.00	
200.00		Total (lines 30 through 199)	0							200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			Title XIX		Hospital		Cost
			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	0 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	0	0	0	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	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	BEHAVIORAL HEALTH	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0 88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	0	0	0 88.01
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0 90.01
91.00	09100	EMERGENCY	0	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0 92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			Title XIX		Hospital		Cost	
			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	3,602,957	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,488,736	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	12,240,318	0.000000	57.00
58.00	05800	MRI	0	0	0	2,220,714	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	16,337,968	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,701,711	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,600,653	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	562,065	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,356	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,277,582	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,198,414	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	695,859	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,467,849	0.000000	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	27,805	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,371,751	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0	0	184,816	0.000000	88.01
90.00	09000	CLINIC	0	0	0	641,507	0.000000	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0.000000	90.01
91.00	09100	EMERGENCY	0	0	0	7,949,786	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	351,971	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	67,923,818		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part IV
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description			Title XIX		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	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	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL 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	ELECTROCARDIOLOGY	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	BEHAVIORAL HEALTH	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0.000000	0	0	0	0	88.01
90.00	09000	CLINIC	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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/27/2020 8:32 am

				Title XIX		Hospital	Cost	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.515218	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.230380	0	0	0	0	54.00
57.00	05700	CT SCAN	0.049118	0	0	0	0	57.00
58.00	05800	MRI	0.287414	0	0	0	0	58.00
60.00	06000	LABORATORY	0.176034	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.213722	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.311087	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.389645	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.306047	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.071055	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.472167	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.676558	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.671477	0	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	6.410286	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1.156374				0	88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0.925526				0	88.01
90.00	09000	CLINIC	0.630548	0	0	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.427166	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.997787	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet D
Part V
Date/Time Prepared:
8/27/2020 8:32 am

				Title XIX	Hospital	Cost
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03550	BEHAVIORAL HEALTH	0	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II - FHCC	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/27/2020 8:32 am

Title XVIII		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,903	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,741	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,512	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	846	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	281	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	11	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	24	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,099	9.00
10.00	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)	776	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	258	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	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 services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	120.63	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,402,565	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,327	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	2,895	25.00
26.00	Total swing-bed cost (see instructions)	1,732,578	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,669,987	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,669,987	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,533.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,685,415	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,685,415	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,268,818	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,954,233	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 III)					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							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
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)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					1,190,066	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					395,666	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,585,732	66.00
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)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
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)						71.00
72.00	Program routine service cost (line 9 x line 71)						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)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						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)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					229	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,533.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					351,192	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/27/2020 8:32 am

		Title XVIII		Hospital	Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x 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	710,860	4,402,565	0.161465	351,192	56,705
91.00	Nursing School cost	0	4,402,565	0.000000	351,192	0
92.00	Allied health cost	0	4,402,565	0.000000	351,192	0
93.00	All other Medical Education	0	4,402,565	0.000000	351,192	0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/27/2020 8:32 am

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,903	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,741	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,512	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	1,127	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	35	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	59	9.00
10.00	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)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	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 services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	120.63	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,402,565	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	4,222	25.00
26.00	Total swing-bed cost (see instructions)	1,732,578	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,669,987	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,669,987	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,533.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	90,482	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	90,482	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					90,482	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 III)					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							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
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)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
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)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
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)						71.00
72.00	Program routine service cost (line 9 x line 71)						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)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						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)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					229	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,533.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					351,192	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet D-1

Date/Time Prepared:
8/27/2020 8:32 am

		Title XIX		Hospital	Cost	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x 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	710,860	4,402,565	0.161465	351,192	56,705	90.00
91.00 Nursing School cost	0	4,402,565	0.000000	351,192	0	91.00
92.00 Allied health cost	0	4,402,565	0.000000	351,192	0	92.00
93.00 All other Medical Education	0	4,402,565	0.000000	351,192	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/27/2020 8:32 am	
Cost Center Description		Title XVIII	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		4,695,906		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.515218	276,820	142,623	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230380	275,741	63,525	54.00
57.00	05700 CT SCAN	0.049118	438,594	21,543	57.00
58.00	05800 MRI	0.287414	78,498	22,561	58.00
60.00	06000 LABORATORY	0.176034	1,050,919	184,997	60.00
65.00	06500 RESPIRATORY THERAPY	0.213722	1,456,916	311,375	65.00
66.00	06600 PHYSICAL THERAPY	0.311087	53,629	16,683	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.389645	27,058	10,543	67.00
68.00	06800 SPEECH PATHOLOGY	0.306047	1,017	311	68.00
69.00	06900 ELECTROCARDIOLOGY	0.071055	27,358	1,944	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.472167	171,695	81,069	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.676558	279,714	189,243	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.671477	326,365	219,147	73.00
76.00	03550 BEHAVIORAL HEALTH	6.410286	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 - FHCC	0.000000		0	88.01
90.00	09000 CLINIC	0.630548	5,160	3,254	90.00
90.01	09001 SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.427166	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.997787	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,469,484	1,268,818	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		4,469,484		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1345 Component CCN: 14-Z345	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/27/2020 8:32 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.515218	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230380	57,058	13,145	54.00
57.00	05700 CT SCAN	0.049118	24,093	1,183	57.00
58.00	05800 MRI	0.287414	0	0	58.00
60.00	06000 LABORATORY	0.176034	288,864	50,850	60.00
65.00	06500 RESPIRATORY THERAPY	0.213722	599,112	128,043	65.00
66.00	06600 PHYSICAL THERAPY	0.311087	364,661	113,441	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.389645	272,383	106,133	67.00
68.00	06800 SPEECH PATHOLOGY	0.306047	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.071055	7,437	528	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.472167	3,006	1,419	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.676558	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.671477	158,639	106,522	73.00
76.00	03550 BEHAVIORAL HEALTH	6.410286	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 - FHCC	0.000000		0	88.01
90.00	09000 CLINIC	0.630548	0	0	90.00
90.01	09001 SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.427166	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.997787	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,775,253	521,264	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,775,253		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet D-3 Date/Time Prepared: 8/27/2020 8:32 am	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.515218	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.230380	0	0	54.00
57.00	05700 CT SCAN	0.049118	0	0	57.00
58.00	05800 MRI	0.287414	0	0	58.00
60.00	06000 LABORATORY	0.176034	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.213722	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.311087	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.389645	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.306047	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.071055	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.472167	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.676558	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.671477	0	0	73.00
76.00	03550 BEHAVIORAL HEALTH	6.410286	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.156374	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II - FHCC	0.925526	0	0	88.01
90.00	09000 CLINIC	0.630548	0	0	90.00
90.01	09001 SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.427166	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.997787	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		0	0	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		0	0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet E Part B Date/Time Prepared: 8/27/2020 8:32 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		6,047,458	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		6,047,458	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
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 instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		6,107,933	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		62,137	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,556,519	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		2,489,277	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		2,489,277	30.00
31.00	Primary payer payments		549	31.00
32.00	Subtotal (line 30 minus line 31)		2,488,728	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		86,368	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		56,139	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		807	36.00
37.00	Subtotal (see instructions)		2,544,867	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		2,544,867	40.00
40.01	Sequestration adjustment (see instructions)		50,897	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		4,620,626	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-2,126,656	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet E-1
Part I
Date/Time Prepared:
8/27/2020 8:32 am

		Title XVIII		Hospital		Cost
		Inpatient Part A		Part 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		2,861,561		5,002,689	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		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
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	10/30/2019	338,893	10/30/2019	382,063	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-338,893		-382,063	3.99
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 appropriate)		2,522,668		4,620,626	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		94,841		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2,126,656	6.02
7.00	Total Medicare program liability (see instructions)		2,617,509		2,493,970	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1345

Period:

Worksheet E-1

Component CCN: 14-Z345

From 04/01/2019
To 03/31/2020Part I
Date/Time Prepared:
8/27/2020 8:32 am

		Title XVIII		Swing Beds - SNF		Cost
		Inpatient Part A		Part 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		2,079,915		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		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
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	10/30/2019	97,622		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-97,622		0	3.99
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 appropriate)		1,982,293		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		89,327		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,071,620		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.		06101		8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet E-1
Part II
Date/Time Prepared:
8/27/2020 8:32 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			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 line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1345 Component CCN:14-Z345	Period: From 04/01/2019 To 03/31/2020	Worksheet E-2 Date/Time Prepared: 8/27/2020 8:32 am
		Title XVIII	Swing Beds - SNF	Cost
		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)	1,601,589	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	526,477	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,034	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,128,066	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,128,066	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,128,066	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	14,168	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	2,113,898	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)	0		16.55
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	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,113,898	0	19.00
19.01	Sequestration adjustment (see instructions)	42,278	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs			19.03
20.00	Interim payments	1,982,293	0	20.00
20.01	Interim payments-PARHM			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	89,327	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
Comparison of PPS versus Cost Reimbursement				
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet E-3 Part V Date/Time Prepared: 8/27/2020 8:32 am
		Title XVIII	Hospital	Cost
			1.00	
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		2,954,233	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)		0	2.00
3.00	Organ acquisition		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,954,233	4.00
5.00	Primary payer payments		136	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,983,639	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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)		2,983,639	19.00
20.00	Deductibles (exclude professional component)		326,920	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		2,656,719	22.00
23.00	Coinsurance		0	23.00
24.00	Subtotal (line 22 minus line 23)		2,656,719	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		21,860	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		14,209	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		276	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,670,928	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	29.50
29.99	Demonstration payment adjustment amount before sequestration		0	29.99
30.00	Subtotal (see instructions)		2,670,928	30.00
30.01	Sequestration adjustment (see instructions)		53,419	30.01
30.02	Demonstration payment adjustment amount after sequestration		0	30.02
30.03	Sequestration adjustment-PARHM		0	30.03
31.00	Interim payments		2,522,668	31.00
31.01	Interim payments-PARHM		0	31.01
32.00	Tentative settlement (for contractor use only)		0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		0	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)		94,841	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		0	33.01
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-1345	Period: From 04/01/2019 To 03/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 8/27/2020 8:32 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services	90,482			1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	90,482		0	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	90,482		0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges	0			8.00
9.00	Ancillary service charges	0		0	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0		0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000		0.000000	15.00
16.00	Total customary charges (see instructions)	0		0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0		0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	90,482		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	90,482		0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	90,482		0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	90,482		0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	90,482		0	31.00
32.00	Deductibles	0		0	32.00
33.00	Coinurance	0		0	33.00
34.00	Allowable bad debts (see instructions)	0		0	34.00
35.00	Utilization review	0			35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	90,482		0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		0	37.00
38.00	Subtotal (line 36 ± line 37)	90,482		0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	90,482		0	40.00
41.00	Interim payments	90,482		0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0			42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

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

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet G

Date/Time Prepared:
8/27/2020 8:32 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	9,649,675	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	17,597,331	0	0	0	4.00
5.00 Other receivable	265,653	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	-14,613,705	0	0	0	6.00
7.00 Inventory	464,989	0	0	0	7.00
8.00 Prepaid expenses	390,966	0	0	0	8.00
9.00 Other current assets	0	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)	13,754,909	0	0	0	11.00
FIXED ASSETS					
12.00 Land	203,353	0	0	0	12.00
13.00 Land improvements	1,189,368	0	0	0	13.00
14.00 Accumulated depreciation	-939,399	0	0	0	14.00
15.00 Buildings	35,135,180	0	0	0	15.00
16.00 Accumulated depreciation	-14,669,045	0	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 Fixed equipment	2,882,800	0	0	0	19.00
20.00 Accumulated depreciation	-1,739,583	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	11,104,379	0	0	0	23.00
24.00 Accumulated depreciation	-8,532,153	0	0	0	24.00
25.00 Minor equipment depreciable	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	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	2,975	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	24,637,875	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	2,713,363	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	0	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	2,713,363	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	41,106,147	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	1,172,328	0	0	0	37.00
38.00 Salaries, wages, and fees payable	1,213,169	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	608,673	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	3,737,580	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	6,731,750	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	16,235,111	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	0	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	16,235,111	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	22,966,861	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	18,139,286				52.00
53.00 Specific purpose fund		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, replacement, and expansion				0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	18,139,286	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	41,106,147	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet G-1

Date/Time Prepared:
8/27/2020 8:32 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,981,485		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,157,931				2.00
3.00	Total (sum of line 1 and line 2)		18,139,416		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		18,139,416		0		11.00
12.00	PRIOR PERIOD ADJUSTMENT	130		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		130		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,139,286		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	PRIOR PERIOD ADJUSTMENT		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
8/27/2020 8:32 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	6,501,470		6,501,470	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	4,836,071		4,836,071	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)	11,337,541		11,337,541	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	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,337,541		11,337,541	17.00
18.00	Ancillary services	8,162,120	57,205,133	65,367,253	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	2,371,751	2,371,751	20.00
20.01	RURAL HEALTH CLINIC II - FHCC	0	184,816	184,816	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	HOSPICE				26.00
27.00	PROFESSIONAL FEES	1,456,497	3,883,887	5,340,384	27.00
27.01	FAMILY HEALTH CENTER	0	923,116	923,116	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	20,956,158	64,568,703	85,524,861	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		28,314,658		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 to Wkst. G-3, line 4)		28,314,658		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2019
To 03/31/2020

Worksheet G-3

Date/Time Prepared:
8/27/2020 8:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	85,524,861	1.00
2.00	Less contractual allowances and discounts on patients' accounts	56,839,284	2.00
3.00	Net patient revenues (line 1 minus line 2)	28,685,577	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	28,314,658	4.00
5.00	Net income from service to patients (line 3 minus line 4)	370,919	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	69,399	6.00
7.00	Income from investments	175,967	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	202,175	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	89,641	22.00
23.00	Governmental appropriations	0	23.00
24.00	PROPERTY TAX REVENUE	263,878	24.00
24.01	340(B) NET REVENUE	0	24.01
24.02	GAIN ON SALE OF ASSETS	0	24.02
24.03	GRANT REVENUE	0	24.03
24.04	OTHER MISCELLANEOUS REVENUE	11,484	24.04
25.00	Total other income (sum of lines 6-24)	812,544	25.00
26.00	Total (line 5 plus line 25)	1,183,463	26.00
27.00	LOSS ON SALE OF ASSETS	25,532	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	25,532	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,157,931	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345

Period:

Worksheet M-1

Component CCN: 14-3413

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/27/2020 8:32 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)
		1.00	2.00	3.00	4.00	5.00
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	462,628	205,985	668,613	0	668,613
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	506,576	33,080	539,656	0	539,656
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	0	0	0	0	0
8.00	Laboratory Technician	0	0	0	0	0
9.00	Other Facility Health Care Staff Costs	414,727	27,082	441,809	0	441,809
10.00	Subtotal (sum of lines 1 through 9)	1,383,931	266,147	1,650,078	0	1,650,078
11.00	Physician Services Under Agreement	0	0	0	0	0
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	0	0	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0
15.00	Medical Supplies	0	19,247	19,247	-2,555	16,692
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	59,453	59,453	0	59,453
19.00	Other Health Care Costs	0	0	0	0	0
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	78,700	78,700	-2,555	76,145
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,383,931	344,847	1,728,778	-2,555	1,726,223
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
25.01	Telehealth	0	0	0	0	0
25.02	Chronic Care Management	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	1,785	1,785	0	1,785
30.00	Administrative Costs	0	11,143	11,143	0	11,143
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	12,928	12,928	0	12,928
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,383,931	357,775	1,741,706	-2,555	1,739,151

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345

Period:

Worksheet M-1

Component CCN: 14-3413

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/27/2020 8:32 am

		RHC I		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	668,613	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	539,656	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 Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	441,809	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,650,078	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)	0	0	14.00
15.00	Medical Supplies	0	16,692	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	59,453	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	76,145	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,726,223	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	1,785	29.00
30.00	Administrative Costs	0	11,143	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	12,928	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,739,151	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345

Period:

Worksheet M-1

Component CCN: 14-8608

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/27/2020 8:32 am

						RHC II		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassificat ions	Reclassified Trial Balance (col. 3 + col. 4)			
		1.00	2.00	3.00	4.00	5.00			
FACILITY HEALTH CARE STAFF COSTS									
1.00	Physician	0	0	0	32,871	32,871	1.00		
2.00	Physician Assistant	0	0	0	0	0	2.00		
3.00	Nurse Practitioner	0	0	0	20,052	20,052	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	0	0	0	0	0	5.00		
6.00	Clinical Psychologist	0	0	0	0	0	6.00		
7.00	Clinical Social Worker	0	0	0	0	0	7.00		
8.00	Laboratory Technician	0	0	0	0	0	8.00		
9.00	Other Facility Health Care Staff Costs	0	0	0	45,074	45,074	9.00		
10.00	Subtotal (sum of lines 1 through 9)	0	0	0	97,997	97,997	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	0	14.00		
15.00	Medical Supplies	0	0	0	1,884	1,884	15.00		
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00		
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00		
18.00	Professional Liability Insurance	0	0	0	0	0	18.00		
19.00	Other Health Care Costs	0	0	0	5,327	5,327	19.00		
20.00	Allowable GME Costs						20.00		
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	7,211	7,211	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	0	0	105,208	105,208	22.00		
COSTS OTHER THAN RHC/FQHC SERVICES									
23.00	Pharmacy	0	0	0	0	0	23.00		
24.00	Dental	0	0	0	0	0	24.00		
25.00	Optometry	0	0	0	0	0	25.00		
25.01	Telehealth	0	0	0	0	0	25.01		
25.02	Chronic Care Management	0	0	0	0	0	25.02		
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00		
27.00	Nonallowable GME costs						27.00		
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	0	0	4,019	4,019	29.00		
30.00	Administrative Costs	0	0	0	1,132	1,132	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	5,151	5,151	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	0	0	110,359	110,359	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345

Period:

Worksheet M-1

Component CCN: 14-8608

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/27/2020 8:32 am

		RHC II		Cost
		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	32,871	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	20,052	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 Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	45,074	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	97,997	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)	0	0	14.00
15.00	Medical Supplies	0	1,884	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	5,327	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	7,211	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	105,208	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	0	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	4,019	29.00
30.00	Administrative Costs	0	1,132	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	5,151	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	110,359	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1345

Period:

Worksheet M-2

Component CCN: 14-3413

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/27/2020 8:32 am

				RHC I		Cost	
		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.95	2,475	4,200	3,990		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	4.51	10,110	2,100	9,471		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.46	12,585		13,461	13,461	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.46	12,585			13,461	8.00
9.00	Physician Services Under Agreements		332			332	9.00
						1.00	
	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)					1,726,223	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,726,223	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					12,928	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,003,481	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,016,409	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,016,409	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,016,409	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,742,632	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1345

Period:

Worksheet M-2

Component CCN: 14-8608

From 04/01/2019
To 03/31/2020Date/Time Prepared:
8/27/2020 8:32 am

		RHC II		Cost	
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4
	1.00	2.00	3.00	4.00	5.00
VISITS AND PRODUCTIVITY					
Positions					
1.00	Physician	0.13	267	4,200	546
2.00	Physician Assistant	0.00	0	2,100	0
3.00	Nurse Practitioner	0.13	427	2,100	273
4.00	Subtotal (sum of lines 1 through 3)	0.26	694		819
5.00	Visiting Nurse	0.00	0		0
6.00	Clinical Psychologist	0.00	0		0
7.00	Clinical Social Worker	0.00	0		0
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.26	694		819
9.00	Physician Services Under Agreements		0		0
					1.00
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)				105,208
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				0
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				105,208
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				1.000000
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				5,151
15.00	Parent provider overhead allocated to facility (see instructions)				60,693
16.00	Total overhead (sum of lines 14 and 15)				65,844
17.00	Allowable GME overhead (see instructions)				0
18.00	Enter the amount from line 16				65,844
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				65,844
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				171,052

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-1345 Component CCN:14-3413	Period: From 04/01/2019 To 03/31/2020	Worksheet M-3 Date/Time Prepared: 8/27/2020 8:32 am		
			Title XVIII	RHC I	Cost	
				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)			2,742,632	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			39,716	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,702,916	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			13,461	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			332	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			13,793	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			195.96	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)			195.96	195.96	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)			0	1,914	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)			0	375,067	11.00
12.00	Program covered visits for mental health services (from contractor records)			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	Graduate Medical Education Pass Through Cost (see instructions)					15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			0	375,067	16.00
16.01	Total program charges (see instructions)(from contractor's records)				376,888	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)				0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)				0	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.)				271,000	16.04
16.05	Total program cost (see instructions)			0	271,000	16.05
17.00	Primary payer amounts				95	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)				36,317	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				68,114	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)				270,905	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)				32,899	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)				303,804	22.00
23.00	Allowable bad debts (see instructions)				3,483	23.00
23.01	Adjusted reimbursable bad debts (see instructions)				2,264	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)				0	24.00
25.00	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	25.99
26.00	Net reimbursable amount (see instructions)				306,068	26.00
26.01	Sequestration adjustment (see instructions)				6,121	26.01
26.02	Demonstration payment adjustment amount after sequestration				0	26.02
27.00	Interim payments				275,332	27.00
28.00	Tentative settlement (for contractor use only)				0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)				24,615	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2				0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1345 Component CCN: 14-8608	Period: From 04/01/2019 To 03/31/2020	Worksheet M-3 Date/Time Prepared: 8/27/2020 8:32 am		
		Title XVIII	RHC II	Cost		
				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)			171,052	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			0	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			171,052	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			819	4.00	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00	
6.00	Total adjusted visits (line 4 plus line 5)			819	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			208.85	7.00	
			Calculation of Limit (1)			
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)		
			1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)			0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)			208.85	208.85	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	0	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	0	11.00	
12.00	Program covered visits for mental health services (from contractor records)		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	Graduate Medical Education Pass Through Cost (see instructions)				15.00	
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	0	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			0	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			0	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			0	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.)			0	16.04	
16.05	Total program cost (see instructions)		0	0	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			0	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			0	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			0	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			0	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			0	22.00	
23.00	Allowable bad debts (see instructions)			0	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			0	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0	24.00	
25.00	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	25.99	
26.00	Net reimbursable amount (see instructions)			0	26.00	
26.01	Sequestration adjustment (see instructions)			0	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			0	27.00	
28.00	Tentative settlement (for contractor use only)			0	28.00	
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			0	29.00	
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2			0	30.00	

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-1345 Component CCN:14-3413	Period: From 04/01/2019 To 03/31/2020	Worksheet M-4 Date/Time Prepared: 8/27/2020 8:32 am	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1,650,078	1,650,078	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000260	0.001140	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		429	1,881	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		17,106	5,581	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		17,535	7,462	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,726,223	1,726,223	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,016,409	1,016,409	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.010158	0.004323	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		10,325	4,394	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		27,860	11,856	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		94	120	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		296.38	98.80	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		78	99	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		23,118	9,781	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			39,716	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			32,899	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 14-1345 Component CCN: 14-3413	Period: From 04/01/2019 To 03/31/2020	Worksheet M-5 Date/Time Prepared: 8/27/2020 8:32 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		259,404	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider					
3.01		10/30/2019	15,928		3.01
3.02			0		3.02
3.03			0		3.03
3.04			0		3.04
3.05			0		3.05
Provider to Program					
3.50			0		3.50
3.51			0		3.51
3.52			0		3.52
3.53			0		3.53
3.54			0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		15,928		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		275,332		4.00
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)				5.00
Program to Provider					
5.01			0		5.01
5.02			0		5.02
5.03			0		5.03
Provider to Program					
5.50			0		5.50
5.51			0		5.51
5.52			0		5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6.01	SETTLEMENT TO PROVIDER		24,615		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		299,947		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor	NATIONAL GOVERNMENT SERVICES INC.	06101		8.00