

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 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 04/01/2020 To 03/31/2021	Worksheet S Parts I-III Date/Time Prepared: 8/31/2021 5:24 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 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.	Date: 8/31/2021	Time: 5:24 am
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.	

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SALEM TOWNSHIP HOSPITAL (14-1345) for the cost reporting period beginning 04/01/2020 and ending 03/31/2021 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) ALEXANDER NAZARIAN
 Officer or Administrator of Provider(s)

CFO
 Title
08/31/2021 05:24:19 AM
 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	233,395	-2,253,774	0	-1,838	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	-433,820	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-33,053		0	10.00
10.01	RURAL HEALTH CLINIC II	0		36,723		0	10.01
200.00	Total	0	-200,425	-2,250,104	0	-1,838	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 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 5:20 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
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)						04/01/2020	03/31/2021	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.					2	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 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 5:20 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 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/31/2021 5:20 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 04/01/2020
To 03/31/2021Worksheet S-2
Part I
Date/Time Prepared:
8/31/2021 5:20 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	
		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	
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
70.00	Inpatient Psychiatric Facility PPS 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 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 5:20 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				0115.00	
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:	49,294		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 04/01/2020 To 03/31/2021		Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 5:20 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 04/01/2020 To 03/31/2021	Worksheet S-2 Part I Date/Time Prepared: 8/31/2021 5:20 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 04/01/2020 To 03/31/2021		Worksheet S-2 Part II Date/Time Prepared: 8/31/2021 5:20 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.	N					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.	N					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	08/19/2021			Y	08/19/2021
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 04/01/2020
To 03/31/2021Worksheet S-2
Part II
Date/Time Prepared:
8/31/2021 5:20 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		N		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		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		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.		N		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.	DAVID	GOODMAN		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.	608-270-2960	DGOODMAN@WIPFLI.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1345	Period: From 04/01/2020 To 03/31/2021	Worksheet S-2 Part II Date/Time Prepared: 8/31/2021 5:20 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

HFS Supplemental Information

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet S-2
Part IX
Date/Time Prepared:
8/31/2021 5:20 am

		Title V	Title XIX	
		1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	N	N	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.01)	N	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.02)	N	N	3.00
3.01	Do Title V or XIX use W/S D-1 for reimbursement?	N	N	3.01
3.02	Does Title XIX transfer managed care (HMO) days from Worksheet S-3, Part I, column 7, sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26?		Y	3.02
		Inpatient	Outpatient	
		1.00	2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.05)	N	N	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98.06)	N	N	7.00
RHC				
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	8.00
FQHC				
9.00	For fiscal year beginning on/after 10/01/2014, use M-series for Title V and/or Title XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	N	N	9.00
		State		
		1.00		
STATE MEDICAID FORMS				
10.00	Select the state when using state Medicaid forms.			10.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/31/2021 5:20 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	9,125	38,616.00	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	9,125	38,616.00	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	9,125	38,616.00	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	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 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/31/2021 5:20 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)	1,160	106	1,599		1.00
2.00	HMO and other (see instructions)	0	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	615	0	717		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	24		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,775	106	2,340		7.00
8.00	INTENSIVE CARE UNIT					8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,775	106	2,340	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	1,408	0	11,170	0.00	14.02
26.01	RURAL HEALTH CLINIC II	1,725	0	4,067	0.00	6.26
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	172.72
28.00	Observation Bed Days		0	261		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 04/01/2020
To 03/31/2021Worksheet S-3
Part I
Date/Time Prepared:
8/31/2021 5:20 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	363	34	530	1.00
2.00 HMO and other (see instructions)			0	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	363	34	530	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	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 04/01/2020 To 03/31/2021		Worksheet S-8 Date/Time Prepared: 8/31/2021 5:20 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:

Worksheet S-8

Component CCN: 14-3413

From 04/01/2020

To 03/31/2021

Date/Time Prepared:
8/31/2021 5:20 am

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
11.00	Facility hours of operations (1)						
	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 04/01/2020 To 03/31/2021		Worksheet S-8 Date/Time Prepared: 8/31/2021 5:20 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 04/01/2020 To 03/31/2021		Worksheet S-8 Date/Time Prepared: 8/31/2021 5:20 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 04/01/2020 To 03/31/2021	Worksheet S-10 Date/Time Prepared: 8/31/2021 5:20 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)			0.330250	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			3,470,147	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			16,669,106	6.00
7.00	Medicaid cost (line 1 times line 6)			5,504,972	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)			2,034,825	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)			2,034,825	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)	1,649,030	134,486	1,783,516	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	544,592	134,486	679,078	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)	544,592	134,486	679,078	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)			2,342,822	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			45,838	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			70,519	27.01
28.00	Non-Medicare bad debt expense (see instructions)			2,272,303	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			775,109	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			1,454,187	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,489,012	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/31/2021 5:20 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (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		1,579,927	1,579,927	-315,708	1,264,219	1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2		0	0	904,173	904,173	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		587,360	587,360	17,641	605,001	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	172,320	2,975,676	3,147,996	0	3,147,996	4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	787,364	2,485,216	3,272,580	-606,106	2,666,474	5.01
5.02	00591	BUSINESS SERVICES	410,462	420,975	831,437	0	831,437	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	311,829	583,684	895,513	0	895,513	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	62,109	24,693	86,802	0	86,802	8.00
9.00	00900	HOUSEKEEPING	256,190	91,334	347,524	0	347,524	9.00
10.00	01000	DIETARY	343,929	368,768	712,697	-617,326	95,371	10.00
11.00	01100	CAFETERIA	0	0	0	617,326	617,326	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	104,078	1,245	105,323	0	105,323	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	20,646	2,148	22,794	0	22,794	14.02
15.00	01500	PHARMACY	53,488	1,464,959	1,518,447	-459	1,517,988	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	270,673	76,999	347,672	0	347,672	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	437,717	437,717	0	437,717	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,790,927	971,042	2,761,969	-42,462	2,719,507	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	844,872	731,465	1,576,337	-177,952	1,398,385	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	638,920	483,533	1,122,453	-65,977	1,056,476	54.00
57.00	05700	CT SCAN	83,718	116,745	200,463	-10,546	189,917	57.00
58.00	05800	MRI	72,190	437,198	509,388	-4,058	505,330	58.00
60.00	06000	LABORATORY	684,645	2,594,789	3,279,434	0	3,279,434	60.00
65.00	06500	RESPIRATORY THERAPY	384,892	126,228	511,120	0	511,120	65.00
66.00	06600	PHYSICAL THERAPY	0	488,615	488,615	246	488,861	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	123,987	123,987	-85	123,902	67.00
68.00	06800	SPEECH PATHOLOGY	0	246	246	-246	0	68.00
69.00	06900	ELECTROCARDIOLOGY	30,444	37,867	68,311	0	68,311	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,022	5,022	383,759	388,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	202,249	202,249	0	202,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	864	864	0	864	73.00
76.00	03550	BEHAVIORAL HEALTH	152,759	129,071	281,830	0	281,830	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,237,856	424,222	1,662,078	-1,456	1,660,622	88.00
88.01	08801	RURAL HEALTH CLINIC II	595,277	90,614	685,891	-63	685,828	88.01
90.00	09000	CLINIC	126,371	36,245	162,616	-12,022	150,594	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,130,983	2,392,534	3,523,517	-68,679	3,454,838	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)	10,566,942	20,493,237	31,060,179	0	31,060,179	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	56,381	41,493	97,874	0	97,874	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	41,806	4,501	46,307	0	46,307	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	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		TOTAL (SUM OF LINES 118 through 199)	10,665,129	20,539,231	31,204,360	0	31,204,360	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet A

Date/Time Prepared:
8/31/2021 5:20 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	-304	1,263,915	1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2	-406	903,767	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,239	603,762	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-87,367	3,060,629	4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	-23,262	2,643,212	5.01
5.02	00591	BUSINESS SERVICES	-59,014	772,423	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	895,513	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	86,802	8.00
9.00	00900	HOUSEKEEPING	0	347,524	9.00
10.00	01000	DIETARY	-17,785	77,586	10.00
11.00	01100	CAFETERIA	-143,034	474,292	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	105,323	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	22,794	14.02
15.00	01500	PHARMACY	0	1,517,988	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	347,672	16.00
17.00	01700	SOCIAL SERVICE	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-437,717	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-690,200	2,029,307	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-257,800	1,140,585	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20	1,056,456	54.00
57.00	05700	CT SCAN	0	189,917	57.00
58.00	05800	MRI	0	505,330	58.00
60.00	06000	LABORATORY	0	3,279,434	60.00
65.00	06500	RESPIRATORY THERAPY	-23,754	487,366	65.00
66.00	06600	PHYSICAL THERAPY	0	488,861	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	123,902	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-28,355	39,956	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	388,781	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	202,249	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-581	283	73.00
76.00	03550	BEHAVIORAL HEALTH	0	281,830	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	1,660,622	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	685,828	88.01
90.00	09000	CLINIC	0	150,594	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	90.01
91.00	09100	EMERGENCY	-964,113	2,490,725	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)	-2,734,951	28,325,228	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	97,874	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	46,307	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	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)	-2,734,951	28,469,409	200.00

COST CENTERS USED IN COST REPORT

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet Non-CMS W

Date/Time Prepared:
8/31/2021 5:20 am

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	00101		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.01	ADMINISTRATIVE & ACCOUNTING	00592		5.01
5.02	BUSINESS SERVICES	00591		5.02
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
12.00	MAINTENANCE OF PERSONNEL	01200		12.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
14.01	PURCHASING	01401		14.01
14.02	CENTRAL SERVICES & SUPPLY	01402		14.02
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.00	BEHAVIORAL HEALTH	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
88.01	RURAL HEALTH CLINIC II	08801		88.01
90.00	CLINIC	09000		90.00
90.01	SALEM MEDICAL CLINIC	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS PRIVATE OFFICES	19200		192.00
192.01	TEMPORARILY IDLE SPACE	19201		192.01
192.02	STH FAM HLTH CRT	19202		192.02
192.03	RISE OUTREACH LAB	19203		192.03
194.00	LITIGATION COSTS	07950		194.00
200.00	TOTAL (SUM OF LINES 118 through 199)			200.00

RECLASSIFICATIONS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/31/2021 5:20 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	297,906	319,420		1.00
	0		297,906	319,420		
	B - TO RECLASSIFY SUPPLY COST					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	383,759		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
	0		0	383,759		
	C - TO RECLASS BUILDING DEPRECIATION					
1.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	559,995		1.00
2.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	22,628		2.00
	0		0	582,623		
	F - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	225,450		1.00
2.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	301,406		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	472		3.00
	0		0	527,328		
	G - TO RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	41,465		1.00
2.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	19,288		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,169		3.00
4.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	856		4.00
	0		0	78,778		
	H - RECLASS ST COSTS					
1.00	PHYSICAL THERAPY	66.00	0	246		1.00
	TOTALS		0	246		
500.00	Grand Total: Increases		297,906	1,892,154		500.00

RECLASSIFICATIONS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-6

Date/Time Prepared:
8/31/2021 5:20 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	297,906	319,420	0		1.00
			297,906	319,420			
	B - TO RECLASSIFY SUPPLY COST						
1.00	PHARMACY	15.00	0	459	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	42,462	0		2.00
3.00	OPERATING ROOM	50.00	0	177,952	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	65,977	0		4.00
5.00	CT SCAN	57.00	0	10,546	0		5.00
6.00	MRI	58.00	0	4,058	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	85	0		7.00
8.00	RURAL HEALTH CLINIC	88.00	0	1,456	0		8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	63	0		9.00
10.00	CLINIC	90.00	0	12,022	0		10.00
11.00	EMERGENCY	91.00	0	68,679	0		11.00
			0	383,759			
	C - TO RECLASS BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	582,623	9		1.00
2.00		0.00	0	0	9		2.00
			0	582,623			
	F - TO RECLASS INTEREST EXPENSE						
1.00	ADMINISTRATIVE & ACCOUNTING	5.01	0	527,328	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
			0	527,328			
	G - TO RECLASS OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & ACCOUNTING	5.01	0	78,778	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	14		4.00
			0	78,778			
	H - RECLASS ST COSTS						
1.00	SPEECH PATHOLOGY	68.00	0	246	0		1.00
	TOTALS		0	246			
500.00	Grand Total: Decreases		297,906	1,892,154			500.00

RECLASSIFICATIONS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
8/31/2021 5:20 am

Increases					Decreases				
Cost Center	Line #	Salary	Other		Cost Center	Line #	Salary	Other	
2.00	3.00	4.00	5.00		6.00	7.00	8.00	9.00	
A - TO RECLASS CAFETERIA COST									
1.00	CAFETERIA	11.00	297,906	319,420	DIETARY	10.00	297,906	319,420	1.00
	0		297,906	319,420	0		297,906	319,420	
B - TO RECLASSIFY SUPPLY COST									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	383,759	PHARMACY	15.00	0	459	1.00
2.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	42,462	2.00
3.00		0.00	0	0	OPERATING ROOM	50.00	0	177,952	3.00
4.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	65,977	4.00
5.00		0.00	0	0	CT SCAN	57.00	0	10,546	5.00
6.00		0.00	0	0	MRI	58.00	0	4,058	6.00
7.00		0.00	0	0	OCCUPATIONAL THERAPY	67.00	0	85	7.00
8.00		0.00	0	0	RURAL HEALTH CLINIC	88.00	0	1,456	8.00
9.00		0.00	0	0	RURAL HEALTH CLINIC II	88.01	0	63	9.00
10.00		0.00	0	0	CLINIC	90.00	0	12,022	10.00
11.00		0.00	0	0	EMERGENCY	91.00	0	68,679	11.00
	0		0	383,759	0		0	383,759	
C - TO RECLASS BUILDING DEPRECIATION									
1.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	559,995	CAP REL COSTS-BLDG & FIXT	1.00	0	582,623	1.00
2.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	22,628		0.00	0	0	2.00
	0		0	582,623	0		0	582,623	
F - TO RECLASS INTEREST EXPENSE									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	225,450	ADMINISTRATIVE & ACCOUNTING	5.01	0	527,328	1.00
2.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	301,406		0.00	0	0	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	472		0.00	0	0	3.00
	0		0	527,328	0		0	527,328	
G - TO RECLASS OTHER CAPITAL COSTS									
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	41,465	ADMINISTRATIVE & ACCOUNTING	5.01	0	78,778	1.00
2.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	19,288		0.00	0	0	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,169		0.00	0	0	3.00
4.00	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	0	856		0.00	0	0	4.00
	0		0	78,778	0		0	78,778	
H - RECLASS ST COSTS									
1.00	PHYSICAL THERAPY	66.00	0	246	SPEECH PATHOLOGY	68.00	0	246	1.00
	TOTALS		0	246	TOTALS		0	246	
500.00	Grand Total: Increases		297,906	1,892,154	Grand Total: Decreases		297,906	1,892,154	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part I
Date/Time Prepared:
8/31/2021 5:20 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	1,189,368	2,472	0	2,472	0	2.00	
3.00	Buildings and Fixtures	35,135,180	205,762	0	205,762	0	3.00	
4.00	Building Improvements	0	0	0	0	0	4.00	
5.00	Fixed Equipment	2,882,800	0	0	0	49,157	5.00	
6.00	Movable Equipment	10,025,110	358,643	0	358,643	0	6.00	
7.00	HIT designated Assets	1,079,269	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	50,515,080	566,877	0	566,877	49,157	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	50,515,080	566,877	0	566,877	49,157	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	1,191,840	0				2.00	
3.00	Buildings and Fixtures	35,340,942	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	2,833,643	0				5.00	
6.00	Movable Equipment	10,383,753	0				6.00	
7.00	HIT designated Assets	1,079,269	0				7.00	
8.00	Subtotal (sum of lines 1-7)	51,032,800	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	51,032,800	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part II
Date/Time Prepared:
8/31/2021 5:20 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	1,579,927	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	587,360	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,167,287	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	1,579,927				1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	0	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	587,360				2.00
3.00	Total (sum of lines 1-2)	0	2,167,287				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet A-7
Part III
Date/Time Prepared:
8/31/2021 5:20 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	26,921,667	0	26,921,667	0.529647	0	1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	12,444,758	0	12,444,758	0.244834	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	11,463,022	0	11,463,022	0.225519	0	2.00
3.00	Total (sum of lines 1-2)	50,829,447	0	50,829,447	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	997,304	0	1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	0	0	0	582,623	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	586,122	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,166,049	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	225,146	0	0	41,465	1,263,915	1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	301,000	0	0	20,144	903,767	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	471	0	0	17,169	603,762	2.00
3.00	Total (sum of lines 1-2)	526,617	0	0	78,778	2,771,444	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/31/2021 5:20 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 #		
				3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-304	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP-REL CSTS-BLDGS & FIX #2 (chapter 2)	B	-406	NEW CAP-REL CSTS-BLDGS & FIX #2	1.01	11	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1	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	-3,900	ADMINISTRATIVE & ACCOUNTING	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-6,125	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	-1,964,222			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	-143,034	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	-437,717	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 04/01/2020
To 03/31/2021

Worksheet A-8

Date/Time Prepared:
8/31/2021 5:20 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	2.00	3.00	4.00	5.00			
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	-17,785	DIETARY	10.00	0	34.00
35.00	BUS OFFICE COSTS ASSOC W/ PHYS	A	-37,298	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	-13,237	ADMINISTRATIVE & ACCOUNTING	5.01	0	39.00
40.00	MARKETING	A	-32,883	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	41.00
42.00	SURGERY MISC REV	B	0	OPERATING ROOM	50.00	0	42.00
43.00	PHARMACY MISC REV	B	-581	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
44.00	LAB MISC REV	B	0	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	0	HOUSEKEEPING	9.00	0	46.00
47.00	OTHER MISC REV	B	-5,252	BUSINESS SERVICES	5.02	0	47.00
48.00	PROVIDER BENEFITS	A	-54,484	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
49.00	INT INCOME ON PAT ACCT	B	-16,464	BUSINESS SERVICES	5.02	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,734,951				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 04/01/2020
To 03/31/2021

Worksheet A-8-2

Date/Time Prepared:
8/31/2021 5:20 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	690,200	690,200	0	0	0	1.00
2.00	50.00	OPERATING ROOM	257,800	257,800	0	0	0	2.00
3.00	50.00	OPERATING ROOM	30,400	0	30,400	0	0	3.00
4.00	60.00	LABORATORY	99,834	0	99,834	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	23,754	23,754	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	28,355	28,355	0	0	0	6.00
7.00	76.00	BEHAVIORAL HEALTH	39,000	0	39,000	0	0	7.00
8.00	91.00	EMERGENCY	2,152,998	964,113	1,188,885	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			3,322,341	1,964,222	1,358,119		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	690,200		1.00
2.00	50.00	OPERATING ROOM	0	0	0	257,800		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	23,754		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	28,355		6.00
7.00	76.00	BEHAVIORAL HEALTH	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	964,113		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	1,964,222		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1345		Period: From 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 5:20 am		
				Physical Therapy		Cost		
						1.00		
PART I - GENERAL INFORMATION								
1.00	Total number of weeks worked (excluding aides) (see instructions)						48	1.00
2.00	Line 1 multiplied by 15 hours per week						720	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						335	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						5.71	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	1,805.54	1,807.09	5,316.16	0.00	0.00	9.00	
10.00	AHSEA (see instructions)	55.26	86.34	64.75	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)	43.17	43.17	32.38			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)						99,774	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)						156,024	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)						344,221	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)						600,019	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)						600,019	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)						600,019	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)						14,462	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)						14,462	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)						1,913	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)						16,375	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)						16,375	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 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 5:20 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)	86.34	64.75	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)						600,019	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						16,375	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)						616,394	63.00
64.00	Total cost of outside supplier services (from your records)						482,656	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						14,462	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,913	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						16,375	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						1,913	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						1,913	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 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 5:20 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					48	1.00
2.00	Line 1 multiplied by 15 hours per week					720	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					335	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					5.71	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	984.00	771.33	938.85	0.00	0.00	9.00
10.00	AHSEA (see instructions)	52.38	81.84	61.38	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)	40.92	40.92	30.69			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)					51,542	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					63,126	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					57,627	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					172,295	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)					172,295	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)					172,295	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)					13,708	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)					13,708	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)					1,913	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					15,621	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)					15,621	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

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 14-1345		Period: From 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 5:20 am		
				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)	81.84	61.38	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)						172,295	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						15,621	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)						187,916	63.00
64.00	Total cost of outside supplier services (from your records)						122,779	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						13,708	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,913	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27						15,621	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						1,913	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						1,913	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 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 5:20 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					2	1.00
2.00	Line 1 multiplied by 15 hours per week					30	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					2	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					5.71	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	8.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.64	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)	39.32	39.32	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)					629	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)					629	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)					629	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)					78.63	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					2,359	22.00
23.00	Total salary equivalency (see instructions)					2,359	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)					79	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)					79	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)					11	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					90	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)					90	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 04/01/2020 To 03/31/2021		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/31/2021 5:20 am	
				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		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)	78.64	0.00	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)					2,359	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					90	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)					2,449	63.00
64.00	Total cost of outside supplier services (from your records)					246	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					79	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					11	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					90	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					11	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					11	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 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 5:20 am

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	1,263,915	1,263,915			1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2	903,767	0	903,767		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	603,762		603,762		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,060,629	13,088	0	2,052	3,075,769
5.01	00592	ADMINISTRATIVE & ACCOUNTING	2,643,212	270,178	40,623	102,363	235,516
5.02	00591	BUSINESS SERVICES	772,423	48,765	0	2,016	122,777
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00	00700	OPERATION OF PLANT	895,513	335,079	39,405	12,778	93,274
8.00	00800	LAUNDRY & LINEN SERVICE	86,802	10,458	0	0	18,578
9.00	00900	HOUSEKEEPING	347,524	8,688	0	0	76,632
10.00	01000	DIETARY	77,586	29,109	0	10,464	13,766
11.00	01100	CAFETERIA	474,292	20,915	0	0	89,110
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0
14.01	01401	PURCHASING	105,323	15,623	0	0	31,132
14.02	01402	CENTRAL SERVICES & SUPPLY	22,794	0	15,882	0	6,176
15.00	01500	PHARMACY	1,517,988	0	27,297	414	15,999
16.00	01600	MEDICAL RECORDS & LIBRARY	347,672	30,624	0	2,115	80,964
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,029,307	6,552	385,505	68,058	535,702
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,140,585	98,264	0	69,128	190,112
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,056,456	86,818	0	192,796	191,114
57.00	05700	CT SCAN	189,917	7,381	0	31,605	25,042
58.00	05800	MRI	505,330	5,372	0	0	21,593
60.00	06000	LABORATORY	3,279,434	57,470	0	37,645	204,791
65.00	06500	RESPIRATORY THERAPY	487,366	29,189	37,160	14,602	115,129
66.00	06600	PHYSICAL THERAPY	488,861	69,968	0	2,525	0
67.00	06700	OCCUPATIONAL THERAPY	123,902	11,382	0	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	39,956	0	0	5,092	9,106
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	388,781	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,249	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	283	0	0	0	0
76.00	03550	BEHAVIORAL HEALTH	281,830	0	18,938	0	45,693
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	1,660,622	0	95,982	3,932	370,267
88.01	08801	RURAL HEALTH CLINIC II	685,828	0	86,548	2,388	178,059
90.00	09000	CLINIC	150,594	34,561	0	1,220	37,800
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	2,490,725	66,779	0	33,158	338,067
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,325,228	1,256,263	747,340	594,351	3,046,399
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	97,874	7,652	0	251	16,865
192.00	19200	PHYSICIANS PRIVATE OFFICES	46,307	0	156,427	9,160	12,505
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0
192.02	19202	STH FAM HLTH CRT	0	0	0	0	0
192.03	19203	RISE OUTREACH LAB	0	0	0	0	0
194.00	07950	LITIGATION COSTS	0	0	0	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	28,469,409	1,263,915	903,767	603,762	3,075,769

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 5:20 am

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	3,291,892	3,291,892				5.01
5.02	00591	BUSINESS SERVICES	945,981	123,684	1,069,665			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	1,376,049	179,914	0	0	1,555,963	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115,838	15,145	0	0	14,349	8.00
9.00	00900	HOUSEKEEPING	432,844	56,593	0	0	11,921	9.00
10.00	01000	DIETARY	130,925	17,118	0	0	39,940	10.00
11.00	01100	CAFETERIA	584,317	76,398	0	0	28,697	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	152,078	19,884	0	0	21,436	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	44,852	5,864	0	0	14,546	14.02
15.00	01500	PHARMACY	1,561,698	204,187	0	0	25,001	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	461,375	60,323	0	0	42,018	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	3,025,124	395,526	133,346	0	362,065	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,498,089	195,871	38,977	0	134,826	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,527,184	199,675	97,204	0	119,121	54.00
57.00	05700	CT SCAN	253,945	33,203	157,642	0	10,127	57.00
58.00	05800	MRI	532,295	69,596	27,404	0	7,371	58.00
60.00	06000	LABORATORY	3,579,340	467,996	284,842	0	78,852	60.00
65.00	06500	RESPIRATORY THERAPY	683,446	89,359	46,405	0	74,084	65.00
66.00	06600	PHYSICAL THERAPY	561,354	73,395	26,885	0	96,001	66.00
67.00	06700	OCCUPATIONAL THERAPY	135,284	17,688	4,287	0	15,617	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	54,154	7,080	16,565	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	388,781	50,832	13,501	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,249	26,443	5,127	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	283	37	32,786	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	346,461	45,299	5,749	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,130,803	278,596	27,439	0	87,908	88.00
88.01	08801	RURAL HEALTH CLINIC II	952,823	124,579	12,298	0	79,268	88.01
90.00	09000	CLINIC	224,175	29,310	10,777	0	47,421	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,928,729	382,923	128,431	0	91,626	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)	28,122,368	3,246,518	1,069,665	0	1,402,195	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	122,642	16,035	0	0	10,499	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	224,399	29,339	0	0	143,269	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	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	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	28,469,409	3,291,892	1,069,665	0	1,555,963	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 5:20 am

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	145,332					8.00
9.00	00900	HOUSEKEEPING	18,095	519,453				9.00
10.00	01000	DIETARY	3,269	25,896	217,148			10.00
11.00	01100	CAFETERIA	0	0	0	689,412		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	11,963	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	7,997	0	3,757	0	14.02
15.00	01500	PHARMACY	0	8,378	0	10,172	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,855	0	40,108	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	64,023	154,619	217,148	165,980	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,404	42,272	0	53,054	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,570	36,560	0	59,585	0	54.00
57.00	05700	CT SCAN	0	6,855	0	7,744	0	57.00
58.00	05800	MRI	0	3,808	0	7,571	0	58.00
60.00	06000	LABORATORY	0	36,179	0	84,551	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	12,948	0	43,576	0	65.00
66.00	06600	PHYSICAL THERAPY	5,994	10,663	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	2,666	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	31,609	0	81,026	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	14,852	0	0	0	88.01
90.00	09000	CLINIC	0	19,042	0	11,443	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	22,977	63,980	0	94,723	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)	145,332	485,179	217,148	675,253	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	14,852	0	10,229	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	14,852	0	3,930	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	4,570	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)	145,332	519,453	217,148	689,412	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 5:20 am

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	205,361			14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	0	77,016		14.02
15.00	01500	PHARMACY	0	0	0	0	1,809,436	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	706	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	5,402	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	14,499	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,525	0	0	54.00
57.00	05700	CT SCAN	0	0	2,181	0	0	57.00
58.00	05800	MRI	0	0	176	0	0	58.00
60.00	06000	LABORATORY	0	0	100,364	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,726	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	497	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	101	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	199	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	43,886	50,680	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	22,805	26,336	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,809,436	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	430	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	2,105	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	794	0	0	88.01
90.00	09000	CLINIC	0	0	524	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	5,895	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	204,815	77,016	1,809,436	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	423	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	106	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	17	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	205,361	77,016	1,809,436	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 5:20 am

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	611,385					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	67,100	0	0	4,590,333	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,163	0	0	2,013,155	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,779	0	0	2,110,203	0	54.00
57.00	05700	CT SCAN	85,595	0	0	557,292	0	57.00
58.00	05800	MRI	14,881	0	0	663,102	0	58.00
60.00	06000	LABORATORY	154,654	0	0	4,786,778	0	60.00
65.00	06500	RESPIRATORY THERAPY	25,197	0	0	977,741	0	65.00
66.00	06600	PHYSICAL THERAPY	14,598	0	0	789,387	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,327	0	0	175,304	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,994	0	0	89,658	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	547,680	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	282,960	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,842,542	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	397,939	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	66,304	0	0	2,705,790	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	22,208	0	0	1,206,822	0	88.01
90.00	09000	CLINIC	5,852	0	0	348,544	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	69,733	0	0	3,789,017	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)	611,385	0	0	27,874,247	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	174,680	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	415,895	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	4,587	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)	611,385	0	0	28,469,409	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part I
Date/Time Prepared:
8/31/2021 5:20 am

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	4,590,333	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,013,155	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,110,203	54.00
57.00	05700	CT SCAN	557,292	57.00
58.00	05800	MRI	663,102	58.00
60.00	06000	LABORATORY	4,786,778	60.00
65.00	06500	RESPIRATORY THERAPY	977,741	65.00
66.00	06600	PHYSICAL THERAPY	789,387	66.00
67.00	06700	OCCUPATIONAL THERAPY	175,304	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	89,658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	547,680	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	282,960	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,842,542	73.00
76.00	03550	BEHAVIORAL HEALTH	397,939	76.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	2,705,790	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,206,822	88.01
90.00	09000	CLINIC	348,544	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	90.01
91.00	09100	EMERGENCY	3,789,017	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)		27,874,247	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	174,680	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	415,895	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	192.01
192.02	19202	STH FAM HLTH CRT	4,587	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)	28,469,409	202.00

COST ALLOCATION STATISTICS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet Non-CMS W

Date/Time Prepared:
8/31/2021 5:20 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	NEW CAP-REL CSTS-BLDGS & FIX #2	2	SQUARE FEET	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	3	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.01	ADMINISTRATIVE & ACCOUNTING	-1	ACCUM. COST	5.01
5.02	BUSINESS SERVICES	5	GROSS CHAR GES	5.02
6.00	MAINTENANCE & REPAIRS	6	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	7	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	HOURS OF SERVICE	9.00
10.00	DIETARY	10	MEALS SERVED	10.00
11.00	CAFETERIA	11	FTES	11.00
12.00	MAINTENANCE OF PERSONNEL	12	NUMBER HOUSED	12.00
13.00	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
14.01	PURCHASING	15	COSTED REQUIS.	14.01
14.02	CENTRAL SERVICES & SUPPLY	16	COSTED REQ UIS.	14.02
15.00	PHARMACY	17	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	18	TIME SPENT	16.00
17.00	SOCIAL SERVICE	19	TIME SPENT	17.00
19.00	NONPHYSICIAN ANESTHETISTS	20	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/31/2021 5:20 am

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	13,088	0	2,052	15,140 4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	0	270,178	40,623	102,363	413,164 5.01
5.02	00591	BUSINESS SERVICES	0	48,765	0	2,016	50,781 5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00	00700	OPERATION OF PLANT	0	335,079	39,405	12,778	387,262 7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,458	0	0	10,458 8.00
9.00	00900	HOUSEKEEPING	0	8,688	0	0	8,688 9.00
10.00	01000	DIETARY	0	29,109	0	10,464	39,573 10.00
11.00	01100	CAFETERIA	0	20,915	0	0	20,915 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	15,623	0	0	15,623 14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	15,882	0	15,882 14.02
15.00	01500	PHARMACY	0	0	27,297	414	27,711 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	30,624	0	2,115	32,739 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	6,552	385,505	68,058	460,115 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	98,264	0	69,128	167,392 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	86,818	0	192,796	279,614 54.00
57.00	05700	CT SCAN	0	7,381	0	31,605	38,986 57.00
58.00	05800	MRI	0	5,372	0	0	5,372 58.00
60.00	06000	LABORATORY	0	57,470	0	37,645	95,115 60.00
65.00	06500	RESPIRATORY THERAPY	0	29,189	37,160	14,602	80,951 65.00
66.00	06600	PHYSICAL THERAPY	0	69,968	0	2,525	72,493 66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,382	0	0	11,382 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	5,092	5,092 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	18,938	0	18,938 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	95,982	3,932	99,914 88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	86,548	2,388	88,936 88.01
90.00	09000	CLINIC	0	34,561	0	1,220	35,781 90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0 90.01
91.00	09100	EMERGENCY	0	66,779	0	33,158	99,937 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)	0	1,256,263	747,340	594,351	2,597,954 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	7,652	0	251	7,903 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	156,427	9,160	165,587 192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0 192.01
192.02	19202	STH FAM HLTH CRT	0	0	0	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					0 200.00
201.00		Negative Cost Centers					0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,263,915	903,767	603,762	2,771,444 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
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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	15,140					4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	1,159	414,323				5.01
5.02	00591	BUSINESS SERVICES	604	15,567	66,952			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	459	22,644	0	0	410,365	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91	1,906	0	0	3,784	8.00
9.00	00900	HOUSEKEEPING	377	7,123	0	0	3,144	9.00
10.00	01000	DIETARY	68	2,155	0	0	10,534	10.00
11.00	01100	CAFETERIA	439	9,616	0	0	7,569	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	153	2,503	0	0	5,653	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	30	738	0	0	3,836	14.02
15.00	01500	PHARMACY	79	25,699	0	0	6,594	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	398	7,592	0	0	11,082	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	2,640	49,781	8,344	0	95,488	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	936	24,653	2,439	0	35,559	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	940	25,131	6,082	0	31,417	54.00
57.00	05700	CT SCAN	123	4,179	9,864	0	2,671	57.00
58.00	05800	MRI	106	8,759	1,715	0	1,944	58.00
60.00	06000	LABORATORY	1,008	58,904	17,842	0	20,796	60.00
65.00	06500	RESPIRATORY THERAPY	567	11,247	2,904	0	19,539	65.00
66.00	06600	PHYSICAL THERAPY	0	9,238	1,682	0	25,319	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,226	268	0	4,119	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	45	891	1,037	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,398	845	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,328	321	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5	2,052	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	225	5,701	360	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,822	35,064	1,717	0	23,185	88.00
88.01	08801	RURAL HEALTH CLINIC II	876	15,680	770	0	20,906	88.01
90.00	09000	CLINIC	186	3,689	674	0	12,507	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,664	48,195	8,036	0	24,165	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,995	408,612	66,952	0	369,811	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	83	2,018	0	0	2,769	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	62	3,693	0	0	37,785	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	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)	15,140	414,323	66,952	0	410,365	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
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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	16,239					8.00
9.00	00900	HOUSEKEEPING	2,022	21,354				9.00
10.00	01000	DIETARY	365	1,065	53,760			10.00
11.00	01100	CAFETERIA	0	0	0	38,539		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	669	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	329	0	210	0	14.02
15.00	01500	PHARMACY	0	344	0	569	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	282	0	2,242	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	7,155	6,354	53,760	9,277	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,609	1,738	0	2,966	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,851	1,503	0	3,331	0	54.00
57.00	05700	CT SCAN	0	282	0	433	0	57.00
58.00	05800	MRI	0	157	0	423	0	58.00
60.00	06000	LABORATORY	0	1,487	0	4,727	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	532	0	2,436	0	65.00
66.00	06600	PHYSICAL THERAPY	670	438	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	110	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	1,299	0	4,529	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	611	0	0	0	88.01
90.00	09000	CLINIC	0	783	0	640	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,567	2,630	0	5,295	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)	16,239	19,944	53,760	37,747	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	611	0	572	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	611	0	220	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	188	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)	16,239	21,354	53,760	38,539	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
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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	24,601			14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	0	21,025		14.02
15.00	01500	PHARMACY	0	0	0	0	60,996	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	85	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	647	0	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	1,737	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	183	0	0	54.00
57.00	05700	CT SCAN	0	0	261	0	0	57.00
58.00	05800	MRI	0	0	21	0	0	58.00
60.00	06000	LABORATORY	0	0	12,022	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	327	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	60	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	12	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	24	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,257	13,836	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,732	7,189	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	60,996	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	51	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	252	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	95	0	0	88.01
90.00	09000	CLINIC	0	0	63	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	706	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	24,535	21,025	60,996	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	51	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	2	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	24,601	21,025	60,996	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
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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	54,420					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	5,973	0		699,534	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,884	0		240,913	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,698	0		354,750	0	54.00
57.00	05700	CT SCAN	7,619	0		64,418	0	57.00
58.00	05800	MRI	1,325	0		19,822	0	58.00
60.00	06000	LABORATORY	13,764	0		225,665	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,243	0		120,746	0	65.00
66.00	06600	PHYSICAL THERAPY	1,299	0		111,199	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	207	0		18,214	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	801	0		8,000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		26,336	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		13,570	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		63,053	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0		25,275	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,902	0		173,684	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,977	0		129,851	0	88.01
90.00	09000	CLINIC	521	0		54,844	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		0	0	90.01
91.00	09100	EMERGENCY	6,297	0		199,402	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)	54,420	0	0	2,549,276	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		14,007	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0		207,971	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0		0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0		190	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)	54,420	0	0	2,771,444	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet B
Part II
Date/Time Prepared:
8/31/2021 5:20 am

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	699,534		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	240,913		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	354,750		54.00
57.00	05700	CT SCAN	64,418		57.00
58.00	05800	MRI	19,822		58.00
60.00	06000	LABORATORY	225,665		60.00
65.00	06500	RESPIRATORY THERAPY	120,746		65.00
66.00	06600	PHYSICAL THERAPY	111,199		66.00
67.00	06700	OCCUPATIONAL THERAPY	18,214		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	8,000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,336		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,570		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,053		73.00
76.00	03550	BEHAVIORAL HEALTH	25,275		76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	173,684		88.00
88.01	08801	RURAL HEALTH CLINIC II	129,851		88.01
90.00	09000	CLINIC	54,844		90.00
90.01	09001	SALEM MEDICAL CLINIC	0		90.01
91.00	09100	EMERGENCY	199,402		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)	2,549,276		118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	14,007		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	207,971		192.00
192.01	19201	TEMPORARILY IDLE SPACE	0		192.01
192.02	19202	STH FAM HLTH CRT	190		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)	2,771,444		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 5:20 am

Cost Center Description			CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	
			BLDG & FIXT (SQUARE FEET)	NEW CAP-REL CSTS-BLDGS & FIX #2 (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			
			1.00	1.01	2.00	4.00	5A.01	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	79,284					1.00
1.01	00101	NEW CAP-REL CSTS-BLDGS & FIX #2	0	37,843				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			587,360			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	821	0	1,996	10,282,731		4.00
5.01	00592	ADMINISTRATIVE & ACCOUNTING	16,948	1,701	99,582	787,364	-3,291,892	5.01
5.02	00591	BUSINESS SERVICES	3,059	0	1,961	410,462	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	12,431	311,829	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	656	0	0	62,109	0	8.00
9.00	00900	HOUSEKEEPING	545	0	0	256,190	0	9.00
10.00	01000	DIETARY	1,826	0	10,180	46,023	0	10.00
11.00	01100	CAFETERIA	1,312	0	0	297,906	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	104,078	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	665	0	20,646	0	14.02
15.00	01500	PHARMACY	0	1,143	403	53,488	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,921	0	2,058	270,673	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	411	16,142	66,209	1,790,927	0	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,164	0	67,250	635,572	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,446	0	187,560	638,920	0	54.00
57.00	05700	CT SCAN	463	0	30,746	83,718	0	57.00
58.00	05800	MRI	337	0	0	72,190	0	58.00
60.00	06000	LABORATORY	3,605	0	36,622	684,645	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,831	1,556	14,205	384,892	0	65.00
66.00	06600	PHYSICAL THERAPY	4,389	0	2,456	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	4,954	30,444	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	793	0	152,759	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	4,019	3,825	1,237,856	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,624	2,323	595,277	0	88.01
90.00	09000	CLINIC	2,168	0	1,187	126,371	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,189	0	32,257	1,130,205	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)	78,804	31,293	578,205	10,184,544	-3,291,892	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	480	0	244	56,381	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,550	8,911	41,806	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	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)	1,263,915	903,767	603,762	3,075,769		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.941615	23.882013	1.027925	0.299120		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				15,140		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.001472		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 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 5:20 am

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	25,177,517				5.01
5.02	00591	BUSINESS SERVICES	945,981	84,403,454			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0		6.00
7.00	00700	OPERATION OF PLANT	1,376,049	0	0	71,136	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115,838	0	0	656	17,919 8.00
9.00	00900	HOUSEKEEPING	432,844	0	0	545	2,231 9.00
10.00	01000	DIETARY	130,925	0	0	1,826	403 10.00
11.00	01100	CAFETERIA	584,317	0	0	1,312	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	152,078	0	0	980	0 14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	44,852	0	0	665	0 14.02
15.00	01500	PHARMACY	1,561,698	0	0	1,143	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	461,375	0	0	1,921	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	3,025,124	10,522,036	0	16,553	7,894 30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,498,089	3,075,577	0	6,164	1,776 50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,527,184	7,670,173	0	5,446	2,043 54.00
57.00	05700	CT SCAN	253,945	12,439,235	0	463	0 57.00
58.00	05800	MRI	532,295	2,162,421	0	337	0 58.00
60.00	06000	LABORATORY	3,579,340	22,474,644	0	3,605	0 60.00
65.00	06500	RESPIRATORY THERAPY	683,446	3,661,728	0	3,387	0 65.00
66.00	06600	PHYSICAL THERAPY	561,354	2,121,447	0	4,389	739 66.00
67.00	06700	OCCUPATIONAL THERAPY	135,284	338,251	0	714	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	54,154	1,307,129	0	0	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	388,781	1,065,360	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	202,249	404,526	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	283	2,587,092	0	0	0 73.00
76.00	03550	BEHAVIORAL HEALTH	346,461	453,651	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,130,803	2,165,181	0	4,019	0 88.00
88.01	08801	RURAL HEALTH CLINIC II	952,823	970,384	0	3,624	0 88.01
90.00	09000	CLINIC	224,175	850,389	0	2,168	0 90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0 90.01
91.00	09100	EMERGENCY	2,928,729	10,134,230	0	4,189	2,833 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)	24,830,476	84,403,454	0	64,106	17,919 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	122,642	0	0	480	0 190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	224,399	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	0	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)	3,291,892	1,069,665	0	1,555,963	145,332 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.130747	0.012673	0.000000	21.873074	8.110497 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	414,323	66,952	0	410,365	16,239 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.016456	0.000793	0.000000	5.768739	0.906245 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 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 5:20 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	7,062				10.00
11.00	01100	CAFETERIA	0	0	11,929			11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	168,297	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
14.01	01401	PURCHASING	0	0	207	0	0	14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	21	0	65	0	0	14.02
15.00	01500	PHARMACY	22	0	176	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	18	0	694	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	7,062	2,872	0	67,405	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	111	0	918	0	34,995	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	96	0	1,031	0	0	54.00
57.00	05700	CT SCAN	18	0	134	0	0	57.00
58.00	05800	MRI	10	0	131	0	0	58.00
60.00	06000	LABORATORY	95	0	1,463	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	34	0	754	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	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	83	0	1,402	0	31,835	88.00
88.01	08801	RURAL HEALTH CLINIC II	39	0	0	0	0	88.01
90.00	09000	CLINIC	50	0	198	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	168	0	1,639	0	34,062	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)	1,274	7,062	11,684	0	168,297	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	39	0	177	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	39	0	68	0	0	192.00
192.01	19201	TEMPORARILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	12	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)	519,453	217,148	689,412	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	380.830645	30.748796	57.792942	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	21,354	53,760	38,539	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	15.655425	7.612574	3.230698	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 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 5:20 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	1,819,264				14.01
14.02	01402	CENTRAL SERVICES & SUPPLY	0	0	590,807			14.02
15.00	01500	PHARMACY	0	0	0	100		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,257	0	0	192,025	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	47,860	0	0	21,075	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	128,441	0	0	6,647	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,511	0	0	16,577	54.00
57.00	05700	CT SCAN	0	19,321	0	0	26,884	57.00
58.00	05800	MRI	0	1,563	0	0	4,674	58.00
60.00	06000	LABORATORY	0	889,101	0	0	48,573	60.00
65.00	06500	RESPIRATORY THERAPY	0	24,149	0	0	7,914	65.00
66.00	06600	PHYSICAL THERAPY	0	4,401	0	0	4,585	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	894	0	0	731	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,762	0	0	2,825	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	388,781	388,781	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	202,026	202,026	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	3,807	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	18,651	0	0	20,825	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	7,032	0	0	6,975	88.01
90.00	09000	CLINIC	0	4,644	0	0	1,838	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	52,225	0	0	21,902	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	1,814,426	590,807	100	192,025	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	3,746	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	939	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	153	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	205,361	77,016	1,809,436	611,385	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.112881	0.130357	18,094.360000	3.183882	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	24,601	21,025	60,996	54,420	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.013523	0.035587	609.960000	0.283401	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 04/01/2020
To 03/31/2021

Worksheet B-1

Date/Time Prepared:
8/31/2021 5:20 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	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 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 5:20 am

		Title XVIII		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	4,590,333		4,590,333	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,013,155		2,013,155	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,110,203		2,110,203	0	0	54.00
57.00	05700 CT SCAN	557,292		557,292	0	0	57.00
58.00	05800 MRI	663,102		663,102	0	0	58.00
60.00	06000 LABORATORY	4,786,778		4,786,778	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	977,741	0	977,741	0	0	65.00
66.00	06600 PHYSICAL THERAPY	789,387	0	789,387	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	175,304	0	175,304	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	89,658		89,658	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	547,680		547,680	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	282,960		282,960	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,842,542		1,842,542	0	0	73.00
76.00	03550 BEHAVIORAL HEALTH	397,939		397,939	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	2,705,790		2,705,790	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1,206,822		1,206,822	0	0	88.01
90.00	09000 CLINIC	348,544		348,544	0	0	90.00
90.01	09001 SALEM MEDICAL CLINIC	0		0	0	0	90.01
91.00	09100 EMERGENCY	3,789,017		3,789,017	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	464,619		464,619	0	0	92.00
200.00	Subtotal (see instructions)	28,338,866	0	28,338,866	0	0	200.00
201.00	Less Observation Beds	464,619		464,619	0	0	201.00
202.00	Total (see instructions)	27,874,247	0	27,874,247	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 5:20 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	10,225,091		10,225,091		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	455,155	2,620,422	3,075,577	0.654562	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	706,993	6,963,180	7,670,173	0.275118	0.000000
57.00	05700	CT SCAN	1,047,163	11,392,072	12,439,235	0.044801	0.000000
58.00	05800	MRI	180,956	1,981,465	2,162,421	0.306648	0.000000
60.00	06000	LABORATORY	2,204,253	20,270,391	22,474,644	0.212986	0.000000
65.00	06500	RESPIRATORY THERAPY	2,107,730	1,553,998	3,661,728	0.267016	0.000000
66.00	06600	PHYSICAL THERAPY	312,045	1,809,402	2,121,447	0.372098	0.000000
67.00	06700	OCCUPATIONAL THERAPY	222,522	115,729	338,251	0.518266	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	69,040	1,238,089	1,307,129	0.068592	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,485	832,875	1,065,360	0.514080	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	206,961	197,565	404,526	0.699485	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	741,669	1,845,423	2,587,092	0.712206	0.000000
76.00	03550	BEHAVIORAL HEALTH	0	453,651	453,651	0.877192	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,165,181	2,165,181		
88.01	08801	RURAL HEALTH CLINIC II	0	970,384	970,384		
90.00	09000	CLINIC	13,345	837,044	850,389	0.409864	0.000000
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	0	10,134,230	10,134,230	0.373883	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	320	296,625	296,945	1.564663	0.000000
200.00		Subtotal (see instructions)	18,725,728	65,677,726	84,403,454		
201.00		Less Observation Beds					
202.00		Total (see instructions)	18,725,728	65,677,726	84,403,454		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 5:20 am

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				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 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 5:20 am

				Title XIX		Hospital		Cost		
Cost Center Description				Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
						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	4,590,333		4,590,333	0	0	30.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	2,013,155		2,013,155	0	0	50.00		
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,110,203		2,110,203	0	0	54.00		
57.00	05700	CT SCAN	557,292		557,292	0	0	57.00		
58.00	05800	MRI	663,102		663,102	0	0	58.00		
60.00	06000	LABORATORY	4,786,778		4,786,778	0	0	60.00		
65.00	06500	RESPIRATORY THERAPY	977,741	0	977,741	0	0	65.00		
66.00	06600	PHYSICAL THERAPY	789,387	0	789,387	0	0	66.00		
67.00	06700	OCCUPATIONAL THERAPY	175,304	0	175,304	0	0	67.00		
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00		
69.00	06900	ELECTROCARDIOLOGY	89,658		89,658	0	0	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	547,680		547,680	0	0	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	282,960		282,960	0	0	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	1,842,542		1,842,542	0	0	73.00		
76.00	03550	BEHAVIORAL HEALTH	397,939		397,939	0	0	76.00		
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	2,705,790		2,705,790	0	0	88.00		
88.01	08801	RURAL HEALTH CLINIC II	1,206,822		1,206,822	0	0	88.01		
90.00	09000	CLINIC	348,544		348,544	0	0	90.00		
90.01	09001	SALEM MEDICAL CLINIC	0		0	0	0	90.01		
91.00	09100	EMERGENCY	3,789,017		3,789,017	0	0	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	464,476		464,476	0	0	92.00		
200.00		Subtotal (see instructions)	28,338,723	0	28,338,723	0	0	200.00		
201.00		Less Observation Beds	464,476		464,476	0	0	201.00		
202.00		Total (see instructions)	27,874,247	0	27,874,247	0	0	202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 5:20 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	10,225,091		10,225,091		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	455,155	2,620,422	3,075,577	0.654562	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	706,993	6,963,180	7,670,173	0.275118	0.000000
57.00	05700	CT SCAN	1,047,163	11,392,072	12,439,235	0.044801	0.000000
58.00	05800	MRI	180,956	1,981,465	2,162,421	0.306648	0.000000
60.00	06000	LABORATORY	2,204,253	20,270,391	22,474,644	0.212986	0.000000
65.00	06500	RESPIRATORY THERAPY	2,107,730	1,553,998	3,661,728	0.267016	0.000000
66.00	06600	PHYSICAL THERAPY	312,045	1,809,402	2,121,447	0.372098	0.000000
67.00	06700	OCCUPATIONAL THERAPY	222,522	115,729	338,251	0.518266	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	69,040	1,238,089	1,307,129	0.068592	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	232,485	832,875	1,065,360	0.514080	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	206,961	197,565	404,526	0.699485	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	741,669	1,845,423	2,587,092	0.712206	0.000000
76.00	03550	BEHAVIORAL HEALTH	0	453,651	453,651	0.877192	0.000000
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	2,165,181	2,165,181	1.249683	0.000000
88.01	08801	RURAL HEALTH CLINIC II	0	970,384	970,384	1.243654	0.000000
90.00	09000	CLINIC	13,345	837,044	850,389	0.409864	0.000000
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	0	10,134,230	10,134,230	0.373883	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	320	296,625	296,945	1.564182	0.000000
200.00		Subtotal (see instructions)	18,725,728	65,677,726	84,403,454		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	18,725,728	65,677,726	84,403,454		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet C
Part I
Date/Time Prepared:
8/31/2021 5:20 am

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	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 04/01/2020 To 03/31/2021	Worksheet D Part II Date/Time Prepared: 8/31/2021 5:20 am
Title XVIII				Hospital		Cost
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	240,913	3,075,577	0.078331	252,872	19,808	50.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	354,750	7,670,173	0.046251	465,315	21,521	54.00
57.00 05700 CT SCAN	64,418	12,439,235	0.005179	730,194	3,782	57.00
58.00 05800 MRI	19,822	2,162,421	0.009167	130,554	1,197	58.00
60.00 06000 LABORATORY	225,665	22,474,644	0.010041	1,377,394	13,830	60.00
65.00 06500 RESPIRATORY THERAPY	120,746	3,661,728	0.032975	1,349,543	44,501	65.00
66.00 06600 PHYSICAL THERAPY	111,199	2,121,447	0.052417	44,026	2,308	66.00
67.00 06700 OCCUPATIONAL THERAPY	18,214	338,251	0.053848	19,770	1,065	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	8,000	1,307,129	0.006120	44,977	275	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26,336	1,065,360	0.024720	112,975	2,793	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13,570	404,526	0.033545	136,303	4,572	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	63,053	2,587,092	0.024372	413,277	10,072	73.00
76.00 03550 BEHAVIORAL HEALTH	25,275	453,651	0.055715	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	173,684	2,165,181	0.080217	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	129,851	970,384	0.133814	0	0	88.01
90.00 09000 CLINIC	54,844	850,389	0.064493	9,505	613	90.00
90.01 09001 SALEM MEDICAL CLINIC	0	0	0.000000	0	0	90.01
91.00 09100 EMERGENCY	199,402	10,134,230	0.019676	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	70,805	296,945	0.238445	0	0	92.00
200.00 Total (lines 50 through 199)	1,920,547	74,178,363		5,086,705	126,337	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 5:20 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	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 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 5:20 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	3,075,577	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,670,173	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	12,439,235	0.000000	57.00
58.00	05800	MRI	0	0	0	2,162,421	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	22,474,644	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,661,728	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,121,447	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	338,251	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,307,129	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,065,360	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	404,526	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,587,092	0.000000	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	453,651	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,165,181	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	970,384	0.000000	88.01
90.00	09000	CLINIC	0	0	0	850,389	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	10,134,230	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	296,945	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	74,178,363		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 5:20 am

				Title XVIII		Hospital		Cost	
	Cost Center Description			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	252,872	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	465,315	0	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	730,194	0	0	0	0	57.00
58.00	05800	MRI	0.000000	130,554	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,377,394	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,349,543	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	44,026	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	19,770	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	44,977	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	112,975	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	136,303	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	413,277	0	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0.000000	0	0	0	0	0	76.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	0	0	0	0	0	88.01
90.00	09000	CLINIC	0.000000	9,505	0	0	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		5,086,705	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 5:20 am

				Title XVIII	Hospital	Cost
	Cost Center Description		PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost		
			21.00	24.00		
	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	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		Total (lines 50 through 199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/31/2021 5:20 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	0.654562	0	1,185,789	0	0	50.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.275118	0	2,858,036	0	0	54.00	
57.00	05700	CT SCAN	0.044801	0	4,985,919	0	0	57.00	
58.00	05800	MRI	0.306648	0	819,385	0	0	58.00	
60.00	06000	LABORATORY	0.212986	0	7,253,413	0	0	60.00	
65.00	06500	RESPIRATORY THERAPY	0.267016	0	699,688	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.372098	0	534,738	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.518266	0	60,179	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.068592	0	581,108	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.514080	0	315,845	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.699485	0	93,038	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.712206	0	1,023,017	0	0	73.00	
76.00	03550	BEHAVIORAL HEALTH	0.877192	0	330,471	0	0	76.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00	
88.01	08801	RURAL HEALTH CLINIC II						88.01	
90.00	09000	CLINIC	0.409864	0	470,176	0	0	90.00	
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	0	0	90.01	
91.00	09100	EMERGENCY	0.373883	0	3,666,655	0	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.564663	0	123,392	0	0	92.00	
200.00		Subtotal (see instructions)		0	25,000,849	0	0	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00	
202.00		Net Charges (line 200 - line 201)		0	25,000,849	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part V
Date/Time Prepared:
8/31/2021 5:20 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	776,172	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	786,297	0		54.00
57.00	05700	CT SCAN	223,374	0		57.00
58.00	05800	MRI	251,263	0		58.00
60.00	06000	LABORATORY	1,544,875	0		60.00
65.00	06500	RESPIRATORY THERAPY	186,828	0		65.00
66.00	06600	PHYSICAL THERAPY	198,975	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	31,189	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	39,859	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	162,370	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	65,079	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	728,599	0		73.00
76.00	03550	BEHAVIORAL HEALTH	289,887	0		76.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
88.01	08801	RURAL HEALTH CLINIC II				88.01
90.00	09000	CLINIC	192,708	0		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	1,370,900	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	193,067	0		92.00
200.00		Subtotal (see instructions)	7,041,442	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,041,442	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part I
Date/Time Prepared:
8/31/2021 5:20 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	699,534	195,106	504,428	1,860	271.20	30.00
200.00	Total (lines 30 through 199)	699,534		504,428	1,860		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	106	28,747				30.00
200.00	Total (lines 30 through 199)	106	28,747				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part II
Date/Time Prepared:
8/31/2021 5:20 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)	Hospital Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	240,913	3,075,577	0.078331	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	354,750	7,670,173	0.046251	0	0	54.00
57.00	05700 CT SCAN	64,418	12,439,235	0.005179	0	0	57.00
58.00	05800 MRI	19,822	2,162,421	0.009167	0	0	58.00
60.00	06000 LABORATORY	225,665	22,474,644	0.010041	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	120,746	3,661,728	0.032975	0	0	65.00
66.00	06600 PHYSICAL THERAPY	111,199	2,121,447	0.052417	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	18,214	338,251	0.053848	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	8,000	1,307,129	0.006120	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26,336	1,065,360	0.024720	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	13,570	404,526	0.033545	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	63,053	2,587,092	0.024372	0	0	73.00
76.00	03550 BEHAVIORAL HEALTH	25,275	453,651	0.055715	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	173,684	2,165,181	0.080217	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	129,851	970,384	0.133814	0	0	88.01
90.00	09000 CLINIC	54,844	850,389	0.064493	0	0	90.00
90.01	09001 SALEM MEDICAL CLINIC	0	0	0.000000	0	0	90.01
91.00	09100 EMERGENCY	199,402	10,134,230	0.019676	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	70,783	296,945	0.238371	0	0	92.00
200.00	Total (lines 50 through 199)	1,920,525	74,178,363		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-1345		Period: From 04/01/2020 To 03/31/2021		Worksheet D Part III Date/Time Prepared: 8/31/2021 5:20 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	1,860	0.00	106	30.00		
200.00		Total (lines 30 through 199)	0	0	1,860		106	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. All Other Medical Education Cost				
					9.00	13.00				
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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 5:20 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	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 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 5:20 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	3,075,577	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	7,670,173	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	12,439,235	0.000000	57.00
58.00	05800	MRI	0	0	0	2,162,421	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	22,474,644	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,661,728	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,121,447	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	338,251	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,307,129	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,065,360	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	404,526	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,587,092	0.000000	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	453,651	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,165,181	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	970,384	0.000000	88.01
90.00	09000	CLINIC	0	0	0	850,389	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	10,134,230	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	296,945	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	74,178,363		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 5:20 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	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 INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet D
Part IV
Date/Time Prepared:
8/31/2021 5:20 am

				Title XIX		Hospital		Cost	
Cost Center Description			PSA Adj. Non Physician Anesthetist Cost	PSA Adj. All Other Medical Education Cost					
			21.00	24.00					
	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	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		Total (lines 50 through 199)	0	0					200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1345	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/31/2021 5:20 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)			2,601	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,860	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)			1,599	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			521	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)			196	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			14	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)			10	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,160	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)			463	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)			152	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)			4,590,333	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)			1,689	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)			1,206	25.00
26.00	Total swing-bed cost (see instructions)			1,279,263	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,311,070	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)			3,311,070	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)			1,780.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,064,974	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)			2,064,974	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/31/2021 5:20 am

Cost Center Description		Title XVIII		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)					1,501,367	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,566,341	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)					824,209	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					270,583	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					1,094,792	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)					261	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,780.15	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					464,619	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/31/2021 5:20 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	699,534	4,590,333	0.152393	464,619	70,805
91.00	Nursing School cost	0	4,590,333	0.000000	464,619	0
92.00	Allied health cost	0	4,590,333	0.000000	464,619	0
93.00	All other Medical Education	0	4,590,333	0.000000	464,619	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-1345	Period: From 04/01/2020 To 03/31/2021	Worksheet D-1 Date/Time Prepared: 8/31/2021 5:20 am
Cost Center Description		Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,601 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			1,860 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)			1,599 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)			717 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			14 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)			10 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			106 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			180.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			180.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			4,590,333 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)			2,520 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)			1,800 25.00
26.00	Total swing-bed cost (see instructions)			1,280,286 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,310,047 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)			3,310,047 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)			1,779.59 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			188,637 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)			188,637 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/31/2021 5:20 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)					188,637	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)					261	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,779.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					464,476	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet D-1

Date/Time Prepared:
8/31/2021 5:20 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	699,534	4,590,333	0.152393	464,476	70,783
91.00	Nursing School cost	0	4,590,333	0.000000	464,476	0
92.00	Allied health cost	0	4,590,333	0.000000	464,476	0
93.00	All other Medical Education	0	4,590,333	0.000000	464,476	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1345	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/31/2021 5:20 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		4,979,063		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.654562	252,872	165,520	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.275118	465,315	128,017	54.00
57.00	05700 CT SCAN	0.044801	730,194	32,713	57.00
58.00	05800 MRI	0.306648	130,554	40,034	58.00
60.00	06000 LABORATORY	0.212986	1,377,394	293,366	60.00
65.00	06500 RESPIRATORY THERAPY	0.267016	1,349,543	360,350	65.00
66.00	06600 PHYSICAL THERAPY	0.372098	44,026	16,382	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.518266	19,770	10,246	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.068592	44,977	3,085	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.514080	112,975	58,078	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.699485	136,303	95,342	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.712206	413,277	294,338	73.00
76.00	03550 BEHAVIORAL HEALTH	0.877192	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	0.409864	9,505	3,896	90.00
90.01	09001 SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.373883	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.564663	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,086,705	1,501,367	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)		5,086,705		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1345 Component CCN: 14-Z345	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/31/2021 5:20 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	0.654562	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.275118	37,906	10,429	54.00
57.00	05700 CT SCAN	0.044801	30,764	1,378	57.00
58.00	05800 MRI	0.306648	3,516	1,078	58.00
60.00	06000 LABORATORY	0.212986	215,578	45,915	60.00
65.00	06500 RESPIRATORY THERAPY	0.267016	287,922	76,880	65.00
66.00	06600 PHYSICAL THERAPY	0.372098	213,411	79,410	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.518266	161,787	83,849	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.068592	4,413	303	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.514080	14,290	7,346	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.699485	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.712206	93,299	66,448	73.00
76.00	03550 BEHAVIORAL HEALTH	0.877192	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000 CLINIC	0.409864	218	89	90.00
90.01	09001 SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.373883	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.564663	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,063,104	373,125	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)		1,063,104		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-1345	Period: From 04/01/2020 To 03/31/2021	Worksheet D-3 Date/Time Prepared: 8/31/2021 5:20 am	
		Title XIX	Hospital	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	0.654562	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.275118	0	0	54.00
57.00	05700 CT SCAN	0.044801	0	0	57.00
58.00	05800 MRI	0.306648	0	0	58.00
60.00	06000 LABORATORY	0.212986	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.267016	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.372098	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.518266	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.068592	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.514080	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.699485	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.712206	0	0	73.00
76.00	03550 BEHAVIORAL HEALTH	0.877192	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.249683	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.243654	0	0	88.01
90.00	09000 CLINIC	0.409864	0	0	90.00
90.01	09001 SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100 EMERGENCY	0.373883	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1.564182	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 04/01/2020 To 03/31/2021	Worksheet E Part B Date/Time Prepared: 8/31/2021 5:20 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7,041,442
2.00	Medical and other services reimbursed under OPPS (see instructions)			0
3.00	OPPS payments			0
4.00	Outlier payment (see instructions)			0
4.01	Outlier reconciliation amount (see instructions)			0
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000
6.00	Line 2 times line 5			0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00
8.00	Transitional corridor payment (see instructions)			0
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0
10.00	Organ acquisitions			0
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7,041,442
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0
14.00	Total reasonable charges (sum of lines 12 and 13)			0
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0
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
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000
18.00	Total customary charges (see instructions)			0
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0
21.00	Lesser of cost or charges (see instructions)			7,111,856
22.00	Interns and residents (see instructions)			0
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			53,970
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			3,612,487
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)			3,445,399
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0
30.00	Subtotal (sum of lines 27 through 29)			3,445,399
31.00	Primary payer payments			1,281
32.00	Subtotal (line 30 minus line 31)			3,444,118
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0
34.00	Allowable bad debts (see instructions)			66,210
35.00	Adjusted reimbursable bad debts (see instructions)			43,037
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			31,443
37.00	Subtotal (see instructions)			3,487,155
38.00	MSP-LCC reconciliation amount from PS&R			0
39.00	OTHER ADJUSTMENTS (CRNA ADJ TO PSR)			87,154
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0
39.97	Demonstration payment adjustment amount before sequestration			0
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0
40.00	Subtotal (see instructions)			3,574,309
40.01	Sequestration adjustment (see instructions)			5,719
40.02	Demonstration payment adjustment amount after sequestration			0
40.03	Sequestration adjustment-PARHM pass-throughs			0
41.00	Interim payments			5,822,364
41.01	Interim payments-PARHM			0
42.00	Tentative settlement (for contractors use only)			0
42.01	Tentative settlement-PARHM (for contractor use only)			0
43.00	Balance due provider/program (see instructions)			-2,253,774
43.01	Balance due provider/program-PARHM (see instructions)			0
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0
91.00	Outlier reconciliation adjustment amount (see instructions)			0
92.00	The rate used to calculate the Time Value of Money			0.00
93.00	Time Value of Money (see instructions)			0
94.00	Total (sum of lines 91 and 93)			0

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet E
Part B
Date/Time Prepared:
8/31/2021 5:20 am

Title XVIII

Hospital

Cost

Overrides

1.00

WORKSHEET OVERRIDE VALUES

112.00 Override of Ancillary service charges (line 12)

0 112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet E-1
Part I
Date/Time Prepared:
8/31/2021 5:20 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		2,921,550		5,937,721	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	05/28/2020	27,358		0	3.01
3.02		09/16/2020	68,336	09/16/2020	80,845	3.02
3.03		11/16/2020	39,427		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	03/24/2021	51,480	03/24/2021	196,202	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)		83,641		-115,357	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)		3,005,191		5,822,364	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		233,395		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2,253,774	6.02
7.00	Total Medicare program liability (see instructions)		3,238,586		3,568,590	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1345

Period:

Worksheet E-1

Component CCN: 14-Z345

From 04/01/2020
To 03/31/2021Part I
Date/Time Prepared:
8/31/2021 5:20 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		1,985,384		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	09/16/2020	202,971		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	03/24/2021	278,020		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)		-75,049		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)		1,910,335		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		433,820		0	6.02
7.00	Total Medicare program liability (see instructions)		1,476,515		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021Worksheet E-1
Part II
Date/Time Prepared:
8/31/2021 5:20 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
				Overrides	
				1.00	
	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment				108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-1345 Component CCN:14-Z345	Period: From 04/01/2020 To 03/31/2021	Worksheet E-2 Date/Time Prepared: 8/31/2021 5:20 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)		1,105,740	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)		376,856	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		615	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)		1,482,596	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1,482,596	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)		1,482,596	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		3,715	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1,478,881	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)		1,478,881	0	19.00
19.01	Sequestration adjustment (see instructions)		2,366	0	19.01
19.02	Demonstration payment adjustment amount after sequestration		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		1,910,335	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, 19.02, 19.25, 20, and 21)		-433,820	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 04/01/2020 To 03/31/2021	Worksheet E-3 Part V Date/Time Prepared: 8/31/2021 5:20 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services		3,566,341	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)		3,566,341	4.00
5.00	Primary payer payments		0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		3,602,004	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)		3,602,004	19.00
20.00	Deductibles (exclude professional component)		358,804	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)		3,243,200	22.00
23.00	Coinsurance		1,855	23.00
24.00	Subtotal (line 22 minus line 23)		3,241,345	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		3,740	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		2,431	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		3,243,776	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)		3,243,776	30.00
30.01	Sequestration adjustment (see instructions)		5,190	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		3,005,191	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)		233,395	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 04/01/2020 To 03/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 8/31/2021 5:20 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	188,637		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)	188,637	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)	188,637	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)	188,637	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)	188,637	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)	188,637	0	29.00	
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)	188,637	0	30.00	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	188,637	0	31.00	
32.00	Deductibles	0		32.00	
33.00	Coinurance	0		33.00	
34.00	Allowable bad debts (see instructions)	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)	188,637	0	36.00	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		37.00	
38.00	Subtotal (line 36 ± line 37)	188,637	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)	188,637	0	40.00	
41.00	Interim payments	190,475	0	41.00	
42.00	Balance due provider/program (line 40 minus line 41)	-1,838	0	42.00	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		43.00	
OVERRIDES					
109.00	Override Ancillary service charges (line 9)		0	0	109.00

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 04/01/2020
To 03/31/2021

Worksheet G

Date/Time Prepared:
8/31/2021 5:20 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	20,817,048	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	24,344,441	0	0	0	4.00
5.00	Other receivable	282,447	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-20,127,351	0	0	0	6.00
7.00	Inventory	541,497	0	0	0	7.00
8.00	Prepaid expenses	554,004	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)	26,412,086	0	0	0	11.00
FIXED ASSETS						
12.00	Land	203,353	0	0	0	12.00
13.00	Land improvements	1,191,840	0	0	0	13.00
14.00	Accumulated depreciation	-974,186	0	0	0	14.00
15.00	Buildings	35,340,942	0	0	0	15.00
16.00	Accumulated depreciation	-16,097,398	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	2,833,643	0	0	0	19.00
20.00	Accumulated depreciation	-1,805,457	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	11,463,022	0	0	0	23.00
24.00	Accumulated depreciation	-8,979,788	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)	23,178,946	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	2,736,243	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)	2,736,243	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	52,327,275	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,354,518	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,411,061	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	577,187	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	5,945,858	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,288,624	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	15,598,526	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	7,575,306	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23,173,832	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	32,462,456	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	19,864,819				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)	19,864,819	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	52,327,275	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-1

Date/Time Prepared:
8/31/2021 5:20 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		18,139,286		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		334,812				2.00
3.00	Total (sum of line 1 and line 2)		18,474,098		0		3.00
4.00	PRIOR YEAR BEG ADJ	1,390,721		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)		1,390,721		0		10.00
11.00	Subtotal (line 3 plus line 10)		19,864,819		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		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)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		19,864,819		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	PRIOR YEAR BEG ADJ		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	Deductions (debit adjustments) (specify)		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 04/01/2020
To 03/31/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
8/31/2021 5:20 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	10,226,930		10,226,930	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	3,161,884		3,161,884	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)	13,388,814		13,388,814	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)	13,388,814		13,388,814	17.00
18.00	Ancillary services	8,688,090	52,723,641	61,411,731	18.00
19.00	Outpatient services	16,079	12,090,637	12,106,716	19.00
20.00	RURAL HEALTH CLINIC	0	2,165,181	2,165,181	20.00
20.01	RURAL HEALTH CLINIC II	0	970,384	970,384	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	22,092,983	67,949,843	90,042,826	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		31,204,360		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)		31,204,360		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-1345

Period:
From 04/01/2020
To 03/31/2021

Worksheet G-3

Date/Time Prepared:
8/31/2021 5:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	90,042,826	1.00
2.00	Less contractual allowances and discounts on patients' accounts	59,264,353	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,778,473	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,204,360	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-425,887	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	191,620	6.00
7.00	Income from investments	41,759	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	160,819	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	77,882	22.00
23.00	Governmental appropriations	0	23.00
24.00	PROPERTY TAX INCOME - GENERAL	269,053	24.00
24.01	MISC REVENUE	25,100	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	766,233	25.00
26.00	Total (line 5 plus line 25)	340,346	26.00
27.00	GAIN/LOSS ON SALE OF ASSETS	5,534	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,534	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	334,812	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345

Period:

Worksheet M-1

Component CCN: 14-3413

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 5:20 am

		RHC I		Cost		
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	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	232,632	15,231	247,863	0	247,863
2.00	Physician Assistant	524,299	34,327	558,626	0	558,626
3.00	Nurse Practitioner	0	0	0	0	0
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	480,925	287,937	768,862	0	768,862
10.00	Subtotal (sum of lines 1 through 9)	1,237,856	337,495	1,575,351	0	1,575,351
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	20,107	20,107	-1,456	18,651
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	55,390	55,390	0	55,390
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	75,497	75,497	-1,456	74,041
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,237,856	412,992	1,650,848	-1,456	1,649,392
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	1,405	1,405	0	1,405
30.00	Administrative Costs	0	9,825	9,825	0	9,825
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	11,230	11,230	0	11,230
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,237,856	424,222	1,662,078	-1,456	1,660,622

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345

Period:

Worksheet M-1

Component CCN: 14-3413

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 5:20 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	247,863	1.00
2.00	Physician Assistant	0	558,626	2.00
3.00	Nurse Practitioner	0	0	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	768,862	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,575,351	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	18,651	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	55,390	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	74,041	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,649,392	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	1,405	29.00
30.00	Administrative Costs	0	9,825	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	11,230	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,660,622	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345

Period:

Worksheet M-1

Component CCN: 14-8608

From 04/01/2020
To 03/31/2021Date/Time Prepared:
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		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	54,266	3,329	57,595	0	57,595
2.00	Physician Assistant	124,816	7,657	132,473	0	132,473
3.00	Nurse Practitioner	0	0	0	0	0
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	416,195	25,531	441,726	0	441,726
10.00	Subtotal (sum of lines 1 through 9)	595,277	36,517	631,794	0	631,794
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	7,095	7,095	-63	7,032
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	23,431	23,431	0	23,431
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	30,526	30,526	-63	30,463
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	595,277	67,043	662,320	-63	662,257
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	3,089	3,089	0	3,089
30.00	Administrative Costs	0	20,482	20,482	0	20,482
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	23,571	23,571	0	23,571
32.00	Total facility costs (sum of lines 22, 28 and 31)	595,277	90,614	685,891	-63	685,828

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345

Period:

Worksheet M-1

Component CCN: 14-8608

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 5:20 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	57,595	1.00
2.00	Physician Assistant	0	132,473	2.00
3.00	Nurse Practitioner	0	0	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	441,726	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	631,794	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	7,032	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	23,431	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	30,463	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	662,257	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	3,089	29.00
30.00	Administrative Costs	0	20,482	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	23,571	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	685,828	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1345

Period:

Worksheet M-2

Component CCN: 14-3413

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 5:20 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	0.50	1,619	4,200	2,100		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	3.64	6,468	2,100	7,644		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.14	8,087		9,744	9,744	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	1,078			1,078	6.00
7.00	Clinical Social Worker	0.00	2,005			2,005	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)	4.14	11,170			12,827	8.00
9.00	Physician Services Under Agreements		0			0	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)					1,649,392	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)					1,649,392	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)					11,230	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,045,168	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,056,398	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,056,398	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,056,398	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,705,790	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1345

Period:

Worksheet M-2

Component CCN: 14-8608

From 04/01/2020
To 03/31/2021Date/Time Prepared:
8/31/2021 5:20 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	0.95	1,895	4,200	3,990		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.82	2,172	2,100	1,722		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.77	4,067		5,712	5,712	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)	1.77	4,067			5,712	8.00
9.00	Physician Services Under Agreements		0			0	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)					662,257	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)					662,257	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)					23,571	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					520,994	15.00
16.00	Total overhead (sum of lines 14 and 15)					544,565	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					544,565	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					544,565	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					1,206,822	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 14-1345 Component CCN: 14-3413	Period: From 04/01/2020 To 03/31/2021	Worksheet M-3 Date/Time Prepared: 8/31/2021 5:20 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)			2,705,790	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			2,649	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			2,703,141	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			12,827	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)			12,827	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			210.74	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)			86.31	87.52	8.00
9.00	Rate for Program covered visits (see instructions)			210.74	210.74	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,408	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	296,722	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	296,722	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			279,717	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.)			220,942	16.04	
16.05	Total program cost (see instructions)		0	220,942	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			20,545	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			47,354	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			220,942	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			1,490	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			222,432	22.00	
23.00	Allowable bad debts (see instructions)			440	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			286	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			107	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)			222,718	26.00	
26.01	Sequestration adjustment (see instructions)			356	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			255,415	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)			-33,053	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 04/01/2020 To 03/31/2021	Worksheet M-3 Date/Time Prepared: 8/31/2021 5:20 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)			1,206,822	1.00	
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			50,181	2.00	
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			1,156,641	3.00	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			5,712	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)			5,712	6.00	
7.00	Adjusted cost per visit (line 3 divided by line 6)			202.49	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)			86.31	87.52	8.00
9.00	Rate for Program covered visits (see instructions)			202.49	202.49	9.00
CALCULATION OF SETTLEMENT						
10.00	Program covered visits excluding mental health services (from contractor records)		0	1,725	10.00	
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		0	349,295	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	349,295	16.00	
16.01	Total program charges (see instructions)(from contractor's records)			329,185	16.01	
16.02	Total program preventive charges (see instructions)(from provider's records)			65,322	16.02	
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			69,313	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.)			192,374	16.04	
16.05	Total program cost (see instructions)		0	261,687	16.05	
17.00	Primary payer amounts			0	17.00	
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			39,515	18.00	
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			57,344	19.00	
20.00	Net Medicare cost excluding vaccines (see instructions)			261,687	20.00	
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			33,507	21.00	
22.00	Total reimbursable Program cost (line 20 plus line 21)			295,194	22.00	
23.00	Allowable bad debts (see instructions)			129	23.00	
23.01	Adjusted reimbursable bad debts (see instructions)			84	23.01	
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			52	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)			295,278	26.00	
26.01	Sequestration adjustment (see instructions)			472	26.01	
26.02	Demonstration payment adjustment amount after sequestration			0	26.02	
27.00	Interim payments			258,083	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)			36,723	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 04/01/2020 To 03/31/2021	Worksheet M-4 Date/Time Prepared: 8/31/2021 5:20 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)		1,575,351	1,575,351	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000000	0.000203	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		0	320	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		0	1,295	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		0	1,615	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		1,649,392	1,649,392	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1,056,398	1,056,398	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.000000	0.000979	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		0	1,034	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		0	2,649	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		0	32	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		0.00	82.78	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		0	18	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		0	1,490	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)			2,649	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)			1,490	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 14-1345 Component CCN: 14-8608	Period: From 04/01/2020 To 03/31/2021	Worksheet M-4 Date/Time Prepared: 8/31/2021 5:20 am	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		631,794	631,794	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.000997	0.005065	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		630	3,200	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		9,568	14,139	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		10,198	17,339	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		662,257	662,257	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		544,565	544,565	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.015399	0.026182	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		8,386	14,258	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		18,584	31,597	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		63	320	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		294.98	98.74	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		52	184	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		15,339	18,168	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)			50,181	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)			33,507	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 04/01/2020 To 03/31/2021	Worksheet M-5 Date/Time Prepared: 8/31/2021 5:20 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		249,046	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		03/24/2021	6,369	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)		6,369	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		255,415	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		0	6.01	
6.02	SETTLEMENT TO PROGRAM		33,053	6.02	
7.00	Total Medicare program liability (see instructions)		222,362	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-1345 Component CCN:14-8608	Period: From 04/01/2020 To 03/31/2021	Worksheet M-5 Date/Time Prepared: 8/31/2021 5:20 am	
			RHC II	Cost	
			Part B		
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			258,083	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				0	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)			0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			258,083	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			36,723	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)			294,806	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00