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).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-1345	Period: From 04/01/2022 To 03/31/2023	Worksheet S Parts I-III Date/Time Prepared: 8/29/2023 9:20 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 8/29/2023 Time: 9:20 am
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SALEM TOWNSHIP HOSPITAL (14-1345) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-533,240	-2,357,408	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	96,495	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		28,476		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-32,201		0	10.01
200.00	TOTAL	0	-436,745	-2,361,133	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/29/2023 9:20 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	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SALEM TOWNSHIP HOSPITAL	141345	99914	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SALEM S/B SNF	14Z345	99914		12/17/1986	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	STH RURAL HEALTH CLINIC	143413	99914		07/29/1996	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	STH RURUAL HEALTH CLINIC - FHCC	148608	99914		01/30/2020	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2022	03/31/2023	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 UCPs, including supplemental UCPs, 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 a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/29/2023 9:20 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	
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	24.00
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? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, 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. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00

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		V	XVIII	XIX	
		1.00	2.00	3.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	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

		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

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		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

		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

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				1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)				
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?			N	68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
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

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		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

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		V	XIX	
		1.00	2.00	
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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	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	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) 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			0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I | Date/Time Prepared: 8/29/2023 9:20 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	104,535	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
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified 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 program, 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 program, 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 program, 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 program, 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 program, 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 program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, 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 a hospital-based 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part I Date/Time Prepared: 8/29/2023 9:20 am

						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	Title XIX		
		1.00	2.00	3.00	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	N		155.00
156.00	Subprovider - IPF	N	N	N	N		156.00
157.00	Subprovider - IRF	N	N	N	N		157.00
158.00	SUBPROVIDER						158.00
159.00	SNF	N	N	N	N		159.00
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00
161.00	CMHC		N	N	N		161.00
						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	Zip Code	CBSA	FTE/Campus	
		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	166.00

				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
			Beginning	Ending	
			1.00	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	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part II | Date/Time Prepared: 8/29/2023 9:20 am

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 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 programs 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 coinsurance amounts 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	06/27/2023	Y	06/27/2023	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-2 Part II Date/Time Prepared: 8/29/2023 9:20 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	Were 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 04/01/2022 To 03/31/2023	Worksheet S-2 Part II Date/Time Prepared: 8/29/2023 9:20 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I Date/Time Prepared: 8/29/2023 9:20 am

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
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	41,064.00	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	41,064.00	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	41,064.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
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
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/29/2023 9:20 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	
	PART I - STATISTICAL DATA						
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)	1,053	2	1,711			1.00
2.00	HMO and other (see instructions)	130	115				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	581	0	733			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,634	2	2,444			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,634	2	2,444	0.00	182.51	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
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	1,923	0	15,944	0.00	16.06	26.00
26.01	RURAL HEALTH CLINIC II	2,265	0	5,985	0.00	10.58	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	209.15	27.00
28.00	Observation Bed Days		0	426			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
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-3 Part I | Date/Time Prepared: 8/29/2023 9:20 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
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	277	1	445	1.00
2.00	HMO and other (see instructions)			33	39		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						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	277	1	445	14.00
15.00	CAH visits						15.00
15.10	REH hours and visits						15.10
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
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1345 | Component CCN: 14-3413 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/29/2023 9:20 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	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			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
Component CCN: 14-3413

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

Worksheet S-8

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

RHC I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	09:00	18:30	09:00	18:30		11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 14-1345 | Component CCN: 14-8608 | Period: From 04/01/2022 To 03/31/2023 | Worksheet S-8 | Date/Time Prepared: 8/29/2023 9:20 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	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	
		1.00	2.00	
14.00	RHC/FQHC name, CCN			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	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

Provider CCN: 14-1345
Component CCN: 14-8608

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

Worksheet S-8

Date/Time Prepared:
8/29/2023 9:20 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 04/01/2022 To 03/31/2023 | Worksheet S-10 | Date/Time Prepared: 8/29/2023 9:20 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)	0.227341	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,670,805	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	34,555,900	6.00
7.00	Medicaid cost (line 1 times line 6)	7,855,973	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)	3,185,168	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)	3,185,168	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)	2,270,187	207,226	2,477,413	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	516,107	207,226	723,333	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)	516,107	207,226	723,333	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)	2,002,451	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	17,972	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	27,650	27.01
28.00	Non-Medicare bad debt expense (see instructions)	1,974,801	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	458,631	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,181,964	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,367,132	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A | Date/Time Prepared: 8/29/2023 9:20 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		1,533,103	1,533,103	521,506	2,054,609	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,208,550	1,208,550	0	1,208,550	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	247,024	4,114,345	4,361,369	0	4,361,369	4.00
5.01	00592	ADMINISTRATIVE & GENERAL	2,025,862	3,531,797	5,557,659	-521,553	5,036,106	5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	331,922	786,402	1,118,324	0	1,118,324	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	92,850	37,294	130,144	0	130,144	8.00
9.00	00900	HOUSEKEEPING	341,250	83,537	424,787	0	424,787	9.00
10.00	01000	DIETARY	545,597	478,517	1,024,114	0	1,024,114	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	15,967	831	16,798	0	16,798	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	137,601	1,312	138,913	0	138,913	14.00
15.00	01500	PHARMACY	66,942	1,622,274	1,689,216	-7,420	1,681,796	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	378,559	70,168	448,727	0	448,727	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	468,433	468,433	0	468,433	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,464,620	1,213,704	3,678,324	-32,136	3,646,188	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,046,439	1,499,663	2,546,102	-278,872	2,267,230	50.00
53.00	05300	ANESTHESIOLOGY	0	4,050	4,050	0	4,050	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	765,132	499,655	1,264,787	-78,123	1,186,664	54.00
57.00	05700	CT SCAN	98,719	155,838	254,557	-14,781	239,776	57.00
58.00	05800	MRI	77,336	-38,214	39,122	-7,044	32,078	58.00
60.00	06000	LABORATORY	831,381	1,841,693	2,673,074	0	2,673,074	60.00
65.00	06500	RESPIRATORY THERAPY	446,239	126,336	572,575	-348	572,227	65.00
66.00	06600	PHYSICAL THERAPY	0	647,205	647,205	10,988	658,193	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	108,055	108,055	-12,956	95,099	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,825	1,825	68.00
69.00	06900	ELECTROCARDIOLOGY	48,150	44,968	93,118	0	93,118	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,324	6,324	488,598	494,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	449,978	449,978	0	449,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,149	1,149	0	1,149	73.00
76.00	03550	BEHAVIORAL HEALTH	199,274	139,757	339,031	0	339,031	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,393,256	590,060	1,983,316	1,523	1,984,839	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,185,579	137,145	1,322,724	5,897	1,328,621	88.01
90.00	09000	CLINIC	239,792	57,427	297,219	-8,111	289,108	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	1,514,325	2,423,051	3,937,376	-68,989	3,868,387	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,493,816	23,844,407	38,338,223	4	38,338,227	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	68,686	7,202	75,888	0	75,888	192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	-15,673	720	-14,953	-4	-14,957	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
194.01	07951	MT VERNON SURGICAL CLINIC	27,294	7,243	34,537	0	34,537	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	14,574,123	23,859,572	38,433,695	0	38,433,695	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A | Date/Time Prepared: 8/29/2023 9:20 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	-492,258	1,562,351		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,208,550		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-59,888	4,301,481		4.00
5.01	00592	ADMINISTRATIVE & GENERAL	-127,504	4,908,602		5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-1,111	1,117,213		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	130,144		8.00
9.00	00900	HOUSEKEEPING	0	424,787		9.00
10.00	01000	DIETARY	-217,428	806,686		10.00
11.00	01100	CAFETERIA	0	0		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	0	16,798		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	138,913		14.00
15.00	01500	PHARMACY	0	1,681,796		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	448,727		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-468,433	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-774,000	2,872,188		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-373,590	1,893,640		50.00
53.00	05300	ANESTHESIOLOGY	-4,050	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-25	1,186,639		54.00
57.00	05700	CT SCAN	0	239,776		57.00
58.00	05800	MRI	0	32,078		58.00
60.00	06000	LABORATORY	0	2,673,074		60.00
65.00	06500	RESPIRATORY THERAPY	-36,880	535,347		65.00
66.00	06600	PHYSICAL THERAPY	0	658,193		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	95,099		67.00
68.00	06800	SPEECH PATHOLOGY	0	1,825		68.00
69.00	06900	ELECTROCARDIOLOGY	-38,991	54,127		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	494,922		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	449,978		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-3,877	-2,728		73.00
76.00	03550	BEHAVIORAL HEALTH	-1,599	337,432		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,984,839		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,328,621		88.01
90.00	09000	CLINIC	-7,035	282,073		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	-1,073,928	2,794,459		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)	-3,680,597	34,657,630		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	75,888		192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0		192.01
192.02	19202	STH FAM HLTH CRT	0	-14,957		192.02
192.03	19203	RISE OUTREACH LAB	0	0		192.03
194.00	07950	LITIGATION COSTS	0	0		194.00
194.01	07951	MT VERNON SURGICAL CLINIC	0	34,537		194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-3,680,597	34,753,098		200.00

RECLASSIFICATIONS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/29/2023 9:20 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS THERAPY COSTS					
1.00	PHYSICAL THERAPY	66.00	0	10,990		1.00
2.00	SPEECH PATHOLOGY	68.00	0	1,825		2.00
	TOTALS		0	12,815		
	B - TO RECLASSIFY SUPPLY COST					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	488,598		1.00
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
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	0		0	488,598		
	C - RECLASS DRUG COSTS TO RHC					
1.00	RURAL HEALTH CLINIC	88.00	0	1,523		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	5,897		2.00
	TOTALS		0	7,420		
	F - TO RECLASS INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	492,258		1.00
	0		0	492,258		
	G - TO RECLASS OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	29,248		1.00
2.00		0.00	0	0		2.00
	0		0	29,248		
500.00	Grand Total: Increases		0	1,030,339		500.00

RECLASSIFICATIONS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-6 | Date/Time Prepared: 8/29/2023 9:20 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASS THERAPY COSTS						
1.00	OCCUPATIONAL THERAPY	67.00	0	12,815	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	12,815			
	B - TO RECLASSIFY SUPPLY COST						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	47	0		1.00
3.00	ADULTS & PEDIATRICS	30.00	0	32,136	0		3.00
4.00	OPERATING ROOM	50.00	0	278,872	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	78,123	0		5.00
6.00	CT SCAN	57.00	0	14,781	0		6.00
7.00	MRI	58.00	0	7,044	0		7.00
9.00	RESPIRATORY THERAPY	65.00	0	348	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	2	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	141	0		11.00
15.00	CLINIC	90.00	0	8,111	0		15.00
16.00	EMERGENCY	91.00	0	68,989	0		16.00
17.00	STH FAM HLTH CRT	192.02	0	4	0		17.00
	0		0	488,598			
	C - RECLASS DRUG COSTS TO RHC						
1.00	PHARMACY	15.00	0	7,420	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	7,420			
	F - TO RECLASS INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	492,258	11		1.00
	0		0	492,258			
	G - TO RECLASS OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.01	0	29,248	14		1.00
2.00		0.00	0	0	14		2.00
	0		0	29,248			
500.00	Grand Total: Decreases		0	1,030,339			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part I Date/Time Prepared: 8/29/2023 9:20 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		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	1,191,840	0	0	0	0	2.00
3.00	Buildings and Fixtures	35,340,942	188,771	0	188,771	134,000	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	2,831,440	0	0	0	2,245	5.00
6.00	Movable Equipment	10,606,970	4,875,885	0	4,875,885	505,235	6.00
7.00	HIT designated Assets	1,079,269	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	51,253,814	5,064,656	0	5,064,656	641,480	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	51,253,814	5,064,656	0	5,064,656	641,480	10.00

		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	35,395,713	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	2,829,195	0	5.00
6.00	Movable Equipment	14,977,620	0	6.00
7.00	HIT designated Assets	1,079,269	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,676,990	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	55,676,990	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part II Date/Time Prepared: 8/29/2023 9:20 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	1,533,103	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,170,715	0	37,835	0	0	2.00
3.00	Total (sum of lines 1-2)	2,703,818	0	37,835	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	1,533,103	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,208,550	2.00
3.00	Total (sum of lines 1-2)	0	2,741,653	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-7 Part III | Date/Time Prepared: 8/29/2023 9:20 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	39,416,748	0	39,416,748	0.770352	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	16,056,889	4,306,418	11,750,471	0.229648	0	2.00
3.00	Total (sum of lines 1-2)	55,473,637	4,306,418	51,167,219	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	1,533,103	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,170,715	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,703,818	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	0	0	0	29,248	1,562,351	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	37,835	0	0	0	1,208,550	2.00
3.00	Total (sum of lines 1-2)	37,835	0	0	29,248	2,770,901	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8 | Date/Time Prepared: 8/29/2023 9:20 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-492,258	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-35,140	ADMINISTRATIVE & GENERAL	5.01	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	-1,103	ADMINISTRATIVE & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)	A	-10,124	ADMINISTRATIVE & GENERAL	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	-2,302,813			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	-172,356	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical 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
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	-468,433	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8 | Date/Time Prepared: 8/29/2023 9:20 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
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		0		0.00	9	32.00
33.00	ANESTHESIA EXPENSES	A	-4,050	ANESTHESIOLOGY	53.00	0	33.00
34.00	DIETARY REVENUE	B	-45,072	DIETARY	10.00	0	34.00
35.00	BUS OFFICE COSTS ASSOC W/ PHYS	A	-40,743	ADMINISTRATIVE & GENERAL	5.01	0	35.00
37.00	UNALLOWABLE TRANSPORTATION COSTS	A	-1,599	BEHAVIORAL HEALTH	76.00	0	37.00
39.00	LOBBYING PORTION OF DUES	A	-13,688	ADMINISTRATIVE & GENERAL	5.01	0	39.00
40.00	MARKETING	A	-33,398	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	PHARMACY 340B REVENUE	B	-3,571	DRUGS CHARGED TO PATIENTS	73.00	0	41.00
42.00	SURGERY MISC REVE	B	-1,611	OPERATING ROOM	50.00	0	42.00
43.00	PHARMACY MISC REV	B	-306	DRUGS CHARGED TO PATIENTS	73.00	0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	44.00
45.00	RADIOLOGY MISC REVENUE	B	-25	RADIOLOGY-DIAGNOSTIC	54.00	0	45.00
46.00	FACILITIES MISC REVENUE	B	-1,111	OPERATION OF PLANT	7.00	0	46.00
47.00	OTHER MISC REV	B	-10	ADMINISTRATIVE & GENERAL	5.01	0	47.00
48.00	PROVIDER BENEFITS	A	-26,490	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	48.00
49.00	INT INCOME ON PAT ACCT	B	-26,696	ADMINISTRATIVE & GENERAL	5.01	0	49.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,680,597				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 04/01/2022 To 03/31/2023 | Worksheet A-8-2 | Date/Time Prepared: 8/29/2023 9:20 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	774,000	774,000	0	0	0	1.00
2.00	50.00	OPERATING ROOM	371,979	371,979	0	0	0	2.00
3.00	50.00	OPERATING ROOM	45,000	0	45,000	0	0	3.00
4.00	60.00	LABORATORY	112,872	0	112,872	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	36,880	36,880	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	38,991	38,991	0	0	0	6.00
7.00	76.00	BEHAVIORAL HEALTH	36,000	0	36,000	0	0	7.00
8.00	91.00	EMERGENCY	2,146,138	1,073,928	1,072,210	0	0	8.00
9.00	90.00	CLINIC	7,035	7,035	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,568,895	2,302,813	1,266,082		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	90.00	CLINIC	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	774,000		1.00
2.00	50.00	OPERATING ROOM	0	0	0	371,979		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	36,880		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	38,991		6.00
7.00	76.00	BEHAVIORAL HEALTH	0	0	0	0		7.00
8.00	91.00	EMERGENCY	0	0	0	1,073,928		8.00
9.00	90.00	CLINIC	0	0	0	7,035		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	2,302,813		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/29/2023 9:20 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					260	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					6.22	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	4,129.00	5,658.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	94.84	71.13	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)	47.42	47.42	35.57			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)					391,594	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					402,454	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					794,048	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)					794,048	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)					794,048	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)					12,329	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)					12,329	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)					1,617	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					13,946	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)					13,946	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 04/01/2022 To 03/31/2023 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/29/2023 9:20 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		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)	94.84	71.13	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)	794,048		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	13,946		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)	807,994		63.00
64.00	Total cost of outside supplier services (from your records)	397,062		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	12,329		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,617		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	13,946		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	1,617		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	1,617		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

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		23	1.00
2.00	Line 1 multiplied by 15 hours per week		345	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		128	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		6.22	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	1,723.00	1,051.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	89.92	67.44	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)	44.96	44.96	33.72			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)	154,932	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	70,879	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	225,811	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)	225,811	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)	225,811	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)	5,755	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)	5,755	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)	796	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	6,551	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)	6,551	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	89.92	67.44	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)		225,811	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		6,551	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)		232,362	63.00
64.00	Total cost of outside supplier services (from your records)		128,984	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		5,755	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		796	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		6,551	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		796	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		796	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

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Speech Pathology — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					8	1.00
2.00	Line 1 multiplied by 15 hours per week					120	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					8	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					6.22	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	34.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	86.45	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)	43.23	43.23	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)					2,939	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					2,939	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)					2,939	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)					86.44	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					10,373	22.00
23.00	Total salary equivalency (see instructions)					10,373	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)					346	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)					346	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)					50	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					396	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)					396	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Speech Pathology — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		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)	86.45	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)	10,373		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	396		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)	10,769		63.00
64.00	Total cost of outside supplier services (from your records)	1,825		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	346		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	50		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	396		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	50		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	50		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 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,562,351	1,562,351				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,208,550		1,208,550			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,301,481	10,951	8,471	4,320,903		4.00
5.01	00592	ADMINISTRATIVE & GENERAL	4,908,602	285,960	223,989	621,530	6,040,081	5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,117,213	302,381	233,908	101,833	1,755,335	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130,144	8,750	6,769	28,486	174,149	8.00
9.00	00900	HOUSEKEEPING	424,787	7,270	5,623	104,695	542,375	9.00
10.00	01000	DIETARY	806,686	48,260	37,332	167,388	1,059,666	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	16,798	3,602	0	4,899	25,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	138,913	21,943	16,974	42,216	220,046	14.00
15.00	01500	PHARMACY	1,681,796	15,246	11,794	20,538	1,729,374	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	448,727	25,624	19,821	116,141	610,313	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	2,872,188	220,800	170,799	756,141	4,019,928	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,893,640	82,221	63,602	246,421	2,285,884	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,186,639	72,644	56,193	234,741	1,550,217	54.00
57.00	05700	CT SCAN	239,776	6,176	4,777	30,287	281,016	57.00
58.00	05800	MRI	32,078	4,495	3,477	23,727	63,777	58.00
60.00	06000	LABORATORY	2,673,074	48,087	37,197	255,066	3,013,424	60.00
65.00	06500	RESPIRATORY THERAPY	535,347	45,179	34,948	136,905	752,379	65.00
66.00	06600	PHYSICAL THERAPY	658,193	58,545	45,287	0	762,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,099	9,524	7,367	0	111,990	67.00
68.00	06800	SPEECH PATHOLOGY	1,825	0	0	0	1,825	68.00
69.00	06900	ELECTROCARDIOLOGY	54,127	0	0	14,772	68,899	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	494,922	0	0	0	494,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	449,978	0	0	0	449,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,728	0	0	0	-2,728	73.00
76.00	03550	BEHAVIORAL HEALTH	337,432	10,578	8,182	61,137	417,329	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,984,839	53,609	41,469	427,448	2,507,365	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,328,621	48,340	37,393	358,925	1,773,279	88.01
90.00	09000	CLINIC	282,073	28,919	22,370	73,568	406,930	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	2,794,459	55,877	43,223	464,592	3,358,151	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	34,657,630	1,474,981	1,140,965	4,291,456	34,473,228	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	75,888	87,370	67,585	21,073	251,916	192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	-14,957	0	0	0	-14,957	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
194.01	07951	MT VERNON SURGICAL CLINIC	34,537	0	0	8,374	42,911	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,753,098	1,562,351	1,208,550	4,320,903	34,753,098	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & GENERAL	6,040,081					5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	369,026	0	2,124,361			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,612	0	19,302	230,063		8.00
9.00	00900	HOUSEKEEPING	114,024	0	16,036	0	672,435	9.00
10.00	01000	DIETARY	222,775	0	106,455	0	34,267	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,319	0	7,944	0	2,557	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,260	0	48,402	0	15,580	14.00
15.00	01500	PHARMACY	363,568	0	33,631	0	10,826	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	128,307	0	56,523	0	18,194	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	845,110	0	487,050	230,063	156,775	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	480,564	0	181,368	0	58,380	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	325,904	0	160,241	0	51,580	54.00
57.00	05700	CT SCAN	59,078	0	13,623	0	4,385	57.00
58.00	05800	MRI	13,408	0	9,916	0	3,192	58.00
60.00	06000	LABORATORY	633,515	0	106,072	0	34,144	60.00
65.00	06500	RESPIRATORY THERAPY	158,173	0	99,658	0	32,079	65.00
66.00	06600	PHYSICAL THERAPY	160,201	0	129,141	0	41,569	66.00
67.00	06700	OCCUPATIONAL THERAPY	23,544	0	21,009	0	6,762	67.00
68.00	06800	SPEECH PATHOLOGY	384	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	14,485	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	104,048	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	94,599	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	87,735	0	23,333	0	7,511	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	527,126	0	118,254	0	38,065	88.00
88.01	08801	RURAL HEALTH CLINIC II	372,798	0	106,631	0	34,324	88.01
90.00	09000	CLINIC	85,549	0	63,791	0	20,534	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	705,987	0	123,256	0	39,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	5,978,099	0	1,931,636	230,063	610,399	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	52,961	0	192,725	0	62,036	192.00
192.01	19201	TEMPORAILY 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
194.01	07951	MT VERNON SURGICAL CLINIC	9,021	0	0	0	0	194.01
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)	6,040,081	0	2,124,361	230,063	672,435	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & GENERAL						5.01
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,423,163					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	41,119		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	330,288	14.00
15.00	01500	PHARMACY	0	0	0	0	1,986	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	1,504	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	1,423,163	0	0	13,019	28,243	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	4,243	105,567	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	22,770	54.00
57.00	05700	CT SCAN	0	0	0	0	10,819	57.00
58.00	05800	MRI	0	0	0	0	2,043	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	5,027	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	2,042	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	376	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	279	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	102,946	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	1,053	835	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	7,359	5,689	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	6,179	5,963	88.01
90.00	09000	CLINIC	0	0	0	1,267	4,008	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	7,999	28,263	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)	1,423,163	0	0	41,119	329,812	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	451	192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	0	0	9	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
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	0	0	16	194.01
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)	1,423,163	0	0	41,119	330,288	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & GENERAL						5.01
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	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
15.00	01500	PHARMACY	2,139,385					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	814,841				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	67,729	0	0	7,271,080	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	93,423	0	0	3,209,429	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,641	0	0	2,178,353	54.00
57.00	05700	CT SCAN	0	123,768	0	0	492,689	57.00
58.00	05800	MRI	0	16,831	0	0	109,167	58.00
60.00	06000	LABORATORY	0	180,367	0	0	3,967,522	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,252	0	0	1,073,568	65.00
66.00	06600	PHYSICAL THERAPY	0	24,064	0	0	1,119,042	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,911	0	0	168,592	67.00
68.00	06800	SPEECH PATHOLOGY	0	26	0	0	2,235	68.00
69.00	06900	ELECTROCARDIOLOGY	0	13,216	0	0	96,879	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,738	0	0	607,160	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,279	0	0	651,802	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,139,385	27,722	0	0	2,164,379	73.00
76.00	03550	BEHAVIORAL HEALTH	0	4,732	0	0	542,528	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	18,209	0	0	3,222,067	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	8,042	0	0	2,307,216	88.01
90.00	09000	CLINIC	0	5,945	0	0	588,024	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	120,946	0	0	4,384,277	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)	2,139,385	814,841	0	0	34,156,009	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	560,089	192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	0	0	-14,948	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
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	0	0	51,948	194.01
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)	2,139,385	814,841	0	0	34,753,098	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part I | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00592	ADMINISTRATIVE & GENERAL				5.01
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	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
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	0	7,271,080		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	3,209,429		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,178,353		54.00
57.00	05700	CT SCAN	0	492,689		57.00
58.00	05800	MRI	0	109,167		58.00
60.00	06000	LABORATORY	0	3,967,522		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,073,568		65.00
66.00	06600	PHYSICAL THERAPY	0	1,119,042		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	168,592		67.00
68.00	06800	SPEECH PATHOLOGY	0	2,235		68.00
69.00	06900	ELECTROCARDIOLOGY	0	96,879		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	607,160		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	651,802		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,164,379		73.00
76.00	03550	BEHAVIORAL HEALTH	0	542,528		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	3,222,067		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,307,216		88.01
90.00	09000	CLINIC	0	588,024		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	4,384,277		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	34,156,009		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	560,089		192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0		192.01
192.02	19202	STH FAM HLTH CRT	0	-14,948		192.02
192.03	19203	RISE OUTREACH LAB	0	0		192.03
194.00	07950	LITIGATION COSTS	0	0		194.00
194.01	07951	MT VERNON SURGICAL CLINIC	0	51,948		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	34,753,098		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	10,951	8,471	19,422	19,422	4.00
5.01	00592	ADMINISTRATIVE & GENERAL	0	285,960	223,989	509,949	2,794	5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	302,381	233,908	536,289	458	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,750	6,769	15,519	128	8.00
9.00	00900	HOUSEKEEPING	0	7,270	5,623	12,893	471	9.00
10.00	01000	DIETARY	0	48,260	37,332	85,592	752	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	3,602	0	3,602	22	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,943	16,974	38,917	190	14.00
15.00	01500	PHARMACY	0	15,246	11,794	27,040	92	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,624	19,821	45,445	522	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	220,800	170,799	391,599	3,399	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	82,221	63,602	145,823	1,108	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	72,644	56,193	128,837	1,055	54.00
57.00	05700	CT SCAN	0	6,176	4,777	10,953	136	57.00
58.00	05800	MRI	0	4,495	3,477	7,972	107	58.00
60.00	06000	LABORATORY	0	48,087	37,197	85,284	1,146	60.00
65.00	06500	RESPIRATORY THERAPY	0	45,179	34,948	80,127	615	65.00
66.00	06600	PHYSICAL THERAPY	0	58,545	45,287	103,832	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,524	7,367	16,891	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	66	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	10,578	8,182	18,760	275	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	53,609	41,469	95,078	1,921	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	48,340	37,393	85,733	1,613	88.01
90.00	09000	CLINIC	0	28,919	22,370	51,289	331	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	55,877	43,223	99,100	2,088	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	1,474,981	1,140,965	2,615,946	19,289	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	87,370	67,585	154,955	95	192.00
192.01	19201	TEMPORAILY 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
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	0	0	38	194.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,562,351	1,208,550	2,770,901	19,422	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & GENERAL	512,743					5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	31,327	0	568,074			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,108	0	5,162	23,917		8.00
9.00	00900	HOUSEKEEPING	9,680	0	4,288	0	27,332	9.00
10.00	01000	DIETARY	18,912	0	28,467	0	1,393	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	452	0	2,124	0	104	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,927	0	12,943	0	633	14.00
15.00	01500	PHARMACY	30,864	0	8,993	0	440	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,892	0	15,115	0	740	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	71,728	0	130,243	23,917	6,370	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,796	0	48,499	0	2,373	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,667	0	42,850	0	2,097	54.00
57.00	05700	CT SCAN	5,015	0	3,643	0	178	57.00
58.00	05800	MRI	1,138	0	2,652	0	130	58.00
60.00	06000	LABORATORY	53,781	0	28,365	0	1,388	60.00
65.00	06500	RESPIRATORY THERAPY	13,428	0	26,649	0	1,304	65.00
66.00	06600	PHYSICAL THERAPY	13,600	0	34,533	0	1,690	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,999	0	5,618	0	275	67.00
68.00	06800	SPEECH PATHOLOGY	33	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,230	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,833	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,031	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	7,448	0	6,239	0	305	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,749	0	31,622	0	1,547	88.00
88.01	08801	RURAL HEALTH CLINIC II	31,648	0	28,514	0	1,395	88.01
90.00	09000	CLINIC	7,262	0	17,058	0	835	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	59,933	0	32,960	0	1,613	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	507,481	0	516,537	23,917	24,810	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,496	0	51,537	0	2,522	192.00
192.01	19201	TEMPORAILY 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
194.01	07951	MT VERNON SURGICAL CLINIC	766	0	0	0	0	194.01
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)	512,743	0	568,074	23,917	27,332	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & GENERAL						5.01
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	135,116					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	6,304		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	56,610	14.00
15.00	01500	PHARMACY	0	0	0	0	340	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	258	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	135,116	0	0	1,994	4,841	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	651	18,093	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	3,903	54.00
57.00	05700	CT SCAN	0	0	0	0	1,854	57.00
58.00	05800	MRI	0	0	0	0	350	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	862	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	350	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	64	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	48	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	17,645	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	161	143	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,129	975	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	948	1,022	88.01
90.00	09000	CLINIC	0	0	0	194	687	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	0	1,227	4,844	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)	135,116	0	0	6,304	56,528	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	77	192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	0	0	2	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
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	0	0	3	194.01
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)	135,116	0	0	6,304	56,610	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			15.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & GENERAL						5.01
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	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
15.00	01500	PHARMACY	67,769					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	72,972				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,069	0		775,276	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,371	0		265,714	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,061	0		212,470	54.00
57.00	05700	CT SCAN	0	11,090	0		32,869	57.00
58.00	05800	MRI	0	1,508	0		13,857	58.00
60.00	06000	LABORATORY	0	16,121	0		186,085	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,352	0		125,337	65.00
66.00	06600	PHYSICAL THERAPY	0	2,156	0		156,161	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	440	0		25,287	67.00
68.00	06800	SPEECH PATHOLOGY	0	2	0		35	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,184	0		2,528	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	604	0		9,686	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	383	0		26,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	67,769	2,484	0		70,253	73.00
76.00	03550	BEHAVIORAL HEALTH	0	424	0		33,755	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,632	0		178,653	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	721	0		151,594	88.01
90.00	09000	CLINIC	0	533	0		78,189	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0		0	90.01
91.00	09100	EMERGENCY	0	10,837	0		212,602	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)	67,769	72,972	0	0	2,556,410	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		213,682	192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0		0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	0		2	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
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	0		807	194.01
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)	67,769	72,972	0	0	2,770,901	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B Part II | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00592	ADMINISTRATIVE & GENERAL				5.01
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	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
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	0	775,276		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	265,714		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	212,470		54.00
57.00	05700	CT SCAN	0	32,869		57.00
58.00	05800	MRI	0	13,857		58.00
60.00	06000	LABORATORY	0	186,085		60.00
65.00	06500	RESPIRATORY THERAPY	0	125,337		65.00
66.00	06600	PHYSICAL THERAPY	0	156,161		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	25,287		67.00
68.00	06800	SPEECH PATHOLOGY	0	35		68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,528		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,686		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	26,059		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	70,253		73.00
76.00	03550	BEHAVIORAL HEALTH	0	33,755		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	178,653		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	151,594		88.01
90.00	09000	CLINIC	0	78,189		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	212,602		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	2,556,410		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	213,682		192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0		192.01
192.02	19202	STH FAM HLTH CRT	0	2		192.02
192.03	19203	RISE OUTREACH LAB	0	0		192.03
194.00	07950	LITIGATION COSTS	0	0		194.00
194.01	07951	MT VERNON SURGICAL CLINIC	0	807		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	2,770,901		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	117,127					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		117,127				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	821	821	14,083,864			4.00
5.01	00592	ADMINISTRATIVE & GENERAL	21,438	21,708	2,025,862	-6,040,081	28,730,702	5.01
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	22,669	22,669	331,922	0	1,755,335	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	656	656	92,850	0	174,149	8.00
9.00	00900	HOUSEKEEPING	545	545	341,250	0	542,375	9.00
10.00	01000	DIETARY	3,618	3,618	545,597	0	1,059,666	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	270	0	15,967	0	25,299	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,645	1,645	137,601	0	220,046	14.00
15.00	01500	PHARMACY	1,143	1,143	66,942	0	1,729,374	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,921	1,921	378,559	0	610,313	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	16,553	16,553	2,464,620	0	4,019,928	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,164	6,164	803,204	0	2,285,884	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,446	5,446	765,132	0	1,550,217	54.00
57.00	05700	CT SCAN	463	463	98,719	0	281,016	57.00
58.00	05800	MRI	337	337	77,336	0	63,777	58.00
60.00	06000	LABORATORY	3,605	3,605	831,381	0	3,013,424	60.00
65.00	06500	RESPIRATORY THERAPY	3,387	3,387	446,239	0	752,379	65.00
66.00	06600	PHYSICAL THERAPY	4,389	4,389	0	0	762,025	66.00
67.00	06700	OCCUPATIONAL THERAPY	714	714	0	0	111,990	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,825	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	48,150	0	68,899	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	494,922	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	449,978	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,728	0	73.00
76.00	03550	BEHAVIORAL HEALTH	793	793	199,274	0	417,329	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,019	4,019	1,393,256	0	2,507,365	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,624	3,624	1,169,906	0	1,773,279	88.01
90.00	09000	CLINIC	2,168	2,168	239,792	0	406,930	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	4,189	4,189	1,514,325	0	3,358,151	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)	110,577	110,577	13,987,884	-6,037,353	28,435,875	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	6,550	6,550	68,686	0	251,916	192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	0	14,957	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
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	27,294	0	42,911	194.01
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)	1,562,351	1,208,550	4,320,903		6,040,081	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.338948	10.318287	0.306798		0.210231	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			19,422		512,743	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001379		0.017847	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 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & GENERAL						5.01
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	72,199				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	656	2,444			8.00
9.00	00900	HOUSEKEEPING	0	545	0	70,998		9.00
10.00	01000	DIETARY	0	3,618	0	3,618	2,444	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	270	0	270	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,645	0	1,645	0	14.00
15.00	01500	PHARMACY	0	1,143	0	1,143	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,921	0	1,921	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	16,553	2,444	16,553	2,444	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	6,164	0	6,164	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,446	0	5,446	0	54.00
57.00	05700	CT SCAN	0	463	0	463	0	57.00
58.00	05800	MRI	0	337	0	337	0	58.00
60.00	06000	LABORATORY	0	3,605	0	3,605	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,387	0	3,387	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,389	0	4,389	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	714	0	714	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	793	0	793	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,019	0	4,019	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	3,624	0	3,624	0	88.01
90.00	09000	CLINIC	0	2,168	0	2,168	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	4,189	0	4,189	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	65,649	2,444	64,448	2,444	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	6,550	0	6,550	0	192.00
192.01	19201	TEMPORAILY 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
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	0	0	0	194.01
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	2,124,361	230,063	672,435	1,423,163	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	29.423690	94.133797	9.471182	582.308920	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	568,074	23,917	27,332	135,116	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	7.868170	9.786007	0.384969	55.284779	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 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	CAFETERIA (GROSS SALARIES)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURSING SALARIES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00592	ADMINISTRATIVE & GENERAL						5.01
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	7,784,377			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,438,151		14.00
15.00	01500	PHARMACY	0	0	0	8,648	8,648	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	6,550	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	2,464,620	122,977	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	803,204	459,656	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	99,147	0	54.00
57.00	05700	CT SCAN	0	0	0	47,107	0	57.00
58.00	05800	MRI	0	0	0	8,895	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	21,889	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,892	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,638	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,217	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,324	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	448,252	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	8,648	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	199,274	3,634	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,393,256	24,773	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	1,169,906	25,964	0	88.01
90.00	09000	CLINIC	0	0	239,792	17,451	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0	0	90.01
91.00	09100	EMERGENCY	0	0	1,514,325	123,062	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	7,784,377	1,436,076	8,648	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	1,965	0	192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0	0	0	192.01
192.02	19202	STH FAM HLTH CRT	0	0	0	40	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
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	0	70	0	194.01
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	0	41,119	330,288	2,139,385	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	0.005282	0.229662	247.384944	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	6,304	56,610	67,769	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000810	0.039363	7.836378	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 04/01/2022 To 03/31/2023 | Worksheet B-1 | Date/Time Prepared: 8/29/2023 9:20 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00592	ADMINISTRATIVE & GENERAL					5.01
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	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
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	150,241,174				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	12,486,971	0	0		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	17,224,068	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,470,744	0	0		54.00
57.00	05700	CT SCAN	22,818,582	0	0		57.00
58.00	05800	MRI	3,102,994	0	0		58.00
60.00	06000	LABORATORY	33,265,668	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	4,840,009	0	0		65.00
66.00	06600	PHYSICAL THERAPY	4,436,571	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	905,455	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	4,782	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	2,436,553	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,242,249	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	788,908	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,110,955	0	0		73.00
76.00	03550	BEHAVIORAL HEALTH	872,501	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,357,099	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	1,482,594	0	0		88.01
90.00	09000	CLINIC	1,096,103	0	0		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0		90.01
91.00	09100	EMERGENCY	22,298,368	0	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)	150,241,174	0	0		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0		192.00
192.01	19201	TEMPORAILY IDLE SPACE	0	0	0		192.01
192.02	19202	STH FAM HLTH CRT	0	0	0		192.02
192.03	19203	RISE OUTREACH LAB	0	0	0		192.03
194.00	07950	LITIGATION COSTS	0	0	0		194.00
194.01	07951	MT VERNON SURGICAL CLINIC	0	0	0		194.01
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)	814,841	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.005424	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	72,972	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000486	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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | 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	7,271,080		7,271,080	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,209,429		3,209,429	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,178,353		2,178,353	0	0	54.00
57.00	05700	CT SCAN	492,689		492,689	0	0	57.00
58.00	05800	MRI	109,167		109,167	0	0	58.00
60.00	06000	LABORATORY	3,967,522		3,967,522	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,073,568	0	1,073,568	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,119,042	0	1,119,042	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,592	0	168,592	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,235	0	2,235	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	96,879		96,879	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	607,160		607,160	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	651,802		651,802	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,164,379		2,164,379	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	542,528		542,528	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,222,067		3,222,067	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,307,216		2,307,216	0	0	88.01
90.00	09000	CLINIC	588,024		588,024	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	4,384,277		4,384,277	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,079,262		1,079,262		0	92.00
200.00		Subtotal (see instructions)	35,235,271	0	35,235,271	0	0	200.00
201.00		Less Observation Beds	1,079,262		1,079,262		0	201.00
202.00		Total (see instructions)	34,156,009	0	34,156,009	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges					
			Inpatient	Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,160,282		11,160,282			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,165,291	15,058,777	17,224,068	0.186334	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,455	11,716,289	12,470,744	0.174677	0.000000	54.00
57.00	05700	CT SCAN	1,230,372	21,588,210	22,818,582	0.021592	0.000000	57.00
58.00	05800	MRI	102,960	3,000,034	3,102,994	0.035181	0.000000	58.00
60.00	06000	LABORATORY	2,832,157	30,433,511	33,265,668	0.119268	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,674,641	2,165,368	4,840,009	0.221811	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	554,085	3,882,486	4,436,571	0.252231	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	461,666	443,789	905,455	0.186196	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,682	3,100	4,782	0.467378	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	81,018	2,355,535	2,436,553	0.039761	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,141	1,085,108	1,242,249	0.488759	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	201,364	587,544	788,908	0.826208	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	597,388	4,513,567	5,110,955	0.423478	0.000000	73.00
76.00	03550	BEHAVIORAL HEALTH	0	872,501	872,501	0.621808	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,357,099	3,357,099			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,482,594	1,482,594			88.01
90.00	09000	CLINIC	15,709	1,080,394	1,096,103	0.536468	0.000000	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	0	22,298,368	22,298,368	0.196619	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,326,689	1,326,689	0.813500	0.000000	92.00
200.00		Subtotal (see instructions)	22,990,211	127,250,963	150,241,174			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,990,211	127,250,963	150,241,174			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
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 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/29/2023 9:20 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	7,271,080		7,271,080	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,209,429		3,209,429	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,178,353		2,178,353	0	0	54.00
57.00	05700	CT SCAN	492,689		492,689	0	0	57.00
58.00	05800	MRI	109,167		109,167	0	0	58.00
60.00	06000	LABORATORY	3,967,522		3,967,522	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,073,568	0	1,073,568	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,119,042	0	1,119,042	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	168,592	0	168,592	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,235	0	2,235	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	96,879		96,879	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	607,160		607,160	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	651,802		651,802	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,164,379		2,164,379	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	542,528		542,528	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,222,067		3,222,067	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,307,216		2,307,216	0	0	88.01
90.00	09000	CLINIC	588,024		588,024	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0		0	0	0	90.01
91.00	09100	EMERGENCY	4,384,277		4,384,277	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,079,262		1,079,262		0	92.00
200.00		Subtotal (see instructions)	35,235,271	0	35,235,271	0	0	200.00
201.00		Less Observation Beds	1,079,262		1,079,262		0	201.00
202.00		Total (see instructions)	34,156,009	0	34,156,009	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,160,282		11,160,282			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,165,291	15,058,777	17,224,068	0.186334	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	754,455	11,716,289	12,470,744	0.174677	0.000000	54.00
57.00	05700	CT SCAN	1,230,372	21,588,210	22,818,582	0.021592	0.000000	57.00
58.00	05800	MRI	102,960	3,000,034	3,102,994	0.035181	0.000000	58.00
60.00	06000	LABORATORY	2,832,157	30,433,511	33,265,668	0.119268	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,674,641	2,165,368	4,840,009	0.221811	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	554,085	3,882,486	4,436,571	0.252231	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	461,666	443,789	905,455	0.186196	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,682	3,100	4,782	0.467378	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	81,018	2,355,535	2,436,553	0.039761	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	157,141	1,085,108	1,242,249	0.488759	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	201,364	587,544	788,908	0.826208	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	597,388	4,513,567	5,110,955	0.423478	0.000000	73.00
76.00	03550	BEHAVIORAL HEALTH	0	872,501	872,501	0.621808	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,357,099	3,357,099	0.959777	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,482,594	1,482,594	1.556202	0.000000	88.01
90.00	09000	CLINIC	15,709	1,080,394	1,096,103	0.536468	0.000000	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0	0.000000	0.000000	90.01
91.00	09100	EMERGENCY	0	22,298,368	22,298,368	0.196619	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,326,689	1,326,689	0.813500	0.000000	92.00
200.00		Subtotal (see instructions)	22,990,211	127,250,963	150,241,174			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,990,211	127,250,963	150,241,174			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet C Part I Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
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 04/01/2022 To 03/31/2023 | Worksheet D Part II Date/Time Prepared: 8/29/2023 9:20 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	265,714	17,224,068	0.015427	1,181,193	18,222	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,470	12,470,744	0.017037	454,624	7,745	54.00
57.00	05700	CT SCAN	32,869	22,818,582	0.001440	703,850	1,014	57.00
58.00	05800	MRI	13,857	3,102,994	0.004466	49,172	220	58.00
60.00	06000	LABORATORY	186,085	33,265,668	0.005594	1,597,029	8,934	60.00
65.00	06500	RESPIRATORY THERAPY	125,337	4,840,009	0.025896	1,563,152	40,479	65.00
66.00	06600	PHYSICAL THERAPY	156,161	4,436,571	0.035199	123,151	4,335	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,287	905,455	0.027927	89,413	2,497	67.00
68.00	06800	SPEECH PATHOLOGY	35	4,782	0.007319	903	7	68.00
69.00	06900	ELECTROCARDIOLOGY	2,528	2,436,553	0.001038	45,372	47	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,686	1,242,249	0.007797	86,705	676	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,059	788,908	0.033032	122,772	4,055	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,253	5,110,955	0.013746	310,098	4,263	73.00
76.00	03550	BEHAVIORAL HEALTH	33,755	872,501	0.038688	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	178,653	3,357,099	0.053216	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	151,594	1,482,594	0.102249	0	0	88.01
90.00	09000	CLINIC	78,189	1,096,103	0.071334	10,428	744	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	212,602	22,298,368	0.009534	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	115,076	1,326,689	0.086739	0	0	92.00
200.00		Total (lines 50 through 199)	1,896,210	139,080,892		6,337,862	93,238	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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	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 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

		Cost Center Description	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	17,224,068	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,470,744	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	22,818,582	0.000000	57.00
58.00	05800	MRI	0	0	0	3,102,994	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	33,265,668	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,840,009	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,436,571	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	905,455	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,782	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,436,553	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,242,249	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	788,908	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,110,955	0.000000	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	872,501	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,357,099	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,482,594	0.000000	88.01
90.00	09000	CLINIC	0	0	0	1,096,103	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	22,298,368	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,326,689	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	139,080,892		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/29/2023 9:20 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	1,181,193	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	454,624	0	0	0	54.00
57.00	05700	CT SCAN	0.000000	703,850	0	0	0	57.00
58.00	05800	MRI	0.000000	49,172	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	1,597,029	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,563,152	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	123,151	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	89,413	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	903	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	45,372	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	86,705	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	122,772	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	310,098	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	10,428	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)		6,337,862	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.186334	0	5,960,488	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174677	0	4,257,616	0	0	54.00
57.00	05700	CT SCAN	0.021592	0	8,522,385	0	0	57.00
58.00	05800	MRI	0.035181	0	1,013,232	0	0	58.00
60.00	06000	LABORATORY	0.119268	0	10,110,969	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.221811	0	923,517	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.252231	0	1,387,241	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186196	0	120,949	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.467378	0	2,386	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.039761	0	925,442	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.488759	0	425,140	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.826208	0	241,682	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.423478	0	2,610,198	552	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0.621808	0	681,920	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	0.536468	0	359,311	189	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.196619	0	6,194,945	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.813500	0	360,673	0	0	92.00
200.00		Subtotal (see instructions)		0	44,098,094	741	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	44,098,094	741	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part V Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,110,642	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	743,708	0		54.00
57.00	05700	CT SCAN	184,015	0		57.00
58.00	05800	MRI	35,647	0		58.00
60.00	06000	LABORATORY	1,205,915	0		60.00
65.00	06500	RESPIRATORY THERAPY	204,846	0		65.00
66.00	06600	PHYSICAL THERAPY	349,905	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	22,520	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,115	0		68.00
69.00	06900	ELECTROCARDIOLOGY	36,796	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	207,791	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	199,680	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,105,361	234		73.00
76.00	03550	BEHAVIORAL HEALTH	424,023	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	192,759	101		90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0		90.01
91.00	09100	EMERGENCY	1,218,044	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	293,407	0		92.00
200.00		Subtotal (see instructions)	7,536,174	335		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	7,536,174	335		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part I Date/Time Prepared: 8/29/2023 9:20 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	775,276	198,006	577,270	2,137	270.13	30.00
200.00	Total (lines 30 through 199)	775,276		577,270	2,137		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	2	540	30.00
200.00	Total (lines 30 through 199)	2	540	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part II Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | 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	265,714	17,224,068	0.015427	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,470	12,470,744	0.017037	0	0	54.00
57.00	05700	CT SCAN	32,869	22,818,582	0.001440	0	0	57.00
58.00	05800	MRI	13,857	3,102,994	0.004466	0	0	58.00
60.00	06000	LABORATORY	186,085	33,265,668	0.005594	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	125,337	4,840,009	0.025896	0	0	65.00
66.00	06600	PHYSICAL THERAPY	156,161	4,436,571	0.035199	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,287	905,455	0.027927	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	35	4,782	0.007319	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,528	2,436,553	0.001038	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,686	1,242,249	0.007797	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	26,059	788,908	0.033032	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	70,253	5,110,955	0.013746	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	33,755	872,501	0.038688	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	178,653	3,357,099	0.053216	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	151,594	1,482,594	0.102249	0	0	88.01
90.00	09000	CLINIC	78,189	1,096,103	0.071334	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0	0	0.000000	0	0	90.01
91.00	09100	EMERGENCY	212,602	22,298,368	0.009534	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	115,076	1,326,689	0.086739	0	0	92.00
200.00		Total (lines 50 through 199)	1,896,210	139,080,892		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part III Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | Hospital | Cost

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	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	30.00
200.00		Total (lines 30 through 199)	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	2,137	0.00	2	30.00
200.00		Total (lines 30 through 199)		0	2,137		2	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	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	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 04/01/2022 To 03/31/2023 | Worksheet D Part IV | Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | Hospital | Cost

		Cost Center Description	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	17,224,068	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,470,744	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	22,818,582	0.000000	57.00
58.00	05800	MRI	0	0	0	3,102,994	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	33,265,668	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,840,009	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,436,571	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	905,455	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	4,782	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,436,553	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,242,249	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	788,908	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,110,955	0.000000	73.00
76.00	03550	BEHAVIORAL HEALTH	0	0	0	872,501	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	3,357,099	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	1,482,594	0.000000	88.01
90.00	09000	CLINIC	0	0	0	1,096,103	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	22,298,368	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	1,326,689	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	139,080,892		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D Part IV Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | 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	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

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/29/2023 9:20 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)	2,870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,137	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)	1,711	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	557	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)	176	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,053	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)	435	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)	146	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)	7,271,080	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,857,041	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,414,039	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)	5,414,039	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)	2,533.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,667,754	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)	2,667,754	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,184,297	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	3,852,051	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
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	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	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,102,064	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	369,888	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	1,471,952	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)	426	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,533.48	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,079,262	89.00

	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	775,276	7,271,080	0.106625	1,079,262	115,076	90.00
91.00	Nursing Program cost	0	7,271,080	0.000000	1,079,262	0	91.00
92.00	Allied health cost	0	7,271,080	0.000000	1,079,262	0	92.00
93.00	All other Medical Education	0	7,271,080	0.000000	1,079,262	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,870	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,137	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)	1,711	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)	733	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	-8	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2	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)	7,271,080	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)	1,440	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)	-1,440	25.00
26.00	Total swing-bed cost (see instructions)	1,857,041	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,414,039	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)	5,414,039	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)	2,533.48	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	5,067	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)	5,067	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	5,067	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 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
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	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	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	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)	426	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,533.48	88.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-1 | Date/Time Prepared: 8/29/2023 9:20 am

Title XIX | Hospital | Cost

	Cost Center Description		
		1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,079,262	89.00

	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	775,276	7,271,080	0.106625	1,079,262	115,076	90.00
91.00	Nursing Program cost	0	7,271,080	0.000000	1,079,262	0	91.00
92.00	Allied health cost	0	7,271,080	0.000000	1,079,262	0	92.00
93.00	All other Medical Education	0	7,271,080	0.000000	1,079,262	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | 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		4,685,226		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.186334	1,181,193	220,096	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174677	454,624	79,412	54.00
57.00	05700	CT SCAN	0.021592	703,850	15,198	57.00
58.00	05800	MRI	0.035181	49,172	1,730	58.00
60.00	06000	LABORATORY	0.119268	1,597,029	190,474	60.00
65.00	06500	RESPIRATORY THERAPY	0.221811	1,563,152	346,724	65.00
66.00	06600	PHYSICAL THERAPY	0.252231	123,151	31,062	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186196	89,413	16,648	67.00
68.00	06800	SPEECH PATHOLOGY	0.467378	903	422	68.00
69.00	06900	ELECTROCARDIOLOGY	0.039761	45,372	1,804	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.488759	86,705	42,378	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.826208	122,772	101,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.423478	310,098	131,320	73.00
76.00	03550	BEHAVIORAL HEALTH	0.621808	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.536468	10,428	5,594	90.00
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.196619	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.813500	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,337,862	1,184,297	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		6,337,862		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3

Component CCN: 14-Z345 | Date/Time Prepared: 8/29/2023 9:20 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				30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.186334	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174677	14,889	2,601	54.00
57.00	05700	CT SCAN	0.021592	59,285	1,280	57.00
58.00	05800	MRI	0.035181	12,695	447	58.00
60.00	06000	LABORATORY	0.119268	239,797	28,600	60.00
65.00	06500	RESPIRATORY THERAPY	0.221811	259,274	57,510	65.00
66.00	06600	PHYSICAL THERAPY	0.252231	287,262	72,456	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186196	249,500	46,456	67.00
68.00	06800	SPEECH PATHOLOGY	0.467378	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.039761	8,604	342	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.488759	400	196	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.826208	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.423478	82,956	35,130	73.00
76.00	03550	BEHAVIORAL HEALTH	0.621808	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.536468	748	401	90.00
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.196619	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.813500	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,215,410	245,419	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		1,215,410		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet D-3 | Date/Time Prepared: 8/29/2023 9:20 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	0.186334	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174677	0	0	54.00
57.00	05700	CT SCAN	0.021592	0	0	57.00
58.00	05800	MRI	0.035181	0	0	58.00
60.00	06000	LABORATORY	0.119268	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.221811	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.252231	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.186196	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.467378	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.039761	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.488759	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.826208	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.423478	0	0	73.00
76.00	03550	BEHAVIORAL HEALTH	0.621808	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.959777	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.556202	0	0	88.01
90.00	09000	CLINIC	0.536468	0	0	90.00
90.01	09001	SALEM MEDICAL CLINIC	0.000000	0	0	90.01
91.00	09100	EMERGENCY	0.196619	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.813500	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		201.00
202.00		Net charges (line 200 minus line 201)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1345	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/29/2023 9:20 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,536,509	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,536,509	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	7,611,874	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	68,864	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	6,787,954	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	755,056	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	755,056	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	755,056	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	20,722	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	13,469	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	768,525	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS	89,451	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	857,976	40.00
40.01	Sequestration adjustment (see instructions)	15,015	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	3,200,369	41.00
41.01	Interim payments-PARHM		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-2,357,408	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-1345	Period: From 04/01/2022 To 03/31/2023	Worksheet E Part B Date/Time Prepared: 8/29/2023 9:20 am
	Title XVIII	Hospital	Cost

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I Date/Time Prepared: 8/29/2023 9:20 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		3,882,084		4,468,071	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	09/26/2022	44,020	03/07/2023	36,245	3.01
3.02		11/08/2022	144,156		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		0	11/08/2022	1,262,080	3.50
3.51			0	11/16/2022	41,867	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		188,176		-1,267,702	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)		4,070,260		3,200,369	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		533,240		2,357,408	6.02
7.00	Total Medicare program liability (see instructions)		3,537,020		842,961	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 | Component CCN: 14-Z345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-1 Part I | Date/Time Prepared: 8/29/2023 9:20 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		1,353,189		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	03/07/2023	274,572		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	11/08/2022	29,238		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)		245,334		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)		1,598,523		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		96,495		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,695,018		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 04/01/2022 To 03/31/2023	Worksheet E-1 Part II Date/Time Prepared: 8/29/2023 9:20 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 (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 14-1345 | Component CCN: 14-Z345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet E-2 | Date/Time Prepared: 8/29/2023 9:20 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)	1,486,672	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)	247,873	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	581	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)	1,734,545	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,734,545	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)	1,734,545	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	9,336	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	1,725,209	0	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)	1,725,209	0	19.00
19.01	Sequestration adjustment (see instructions)	30,191	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	1,598,523	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)	96,495	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
	Comparision 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 04/01/2022 To 03/31/2023 | Worksheet E-3 Part V | Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,852,051	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
3.01	Cellular therapy acquisition cost (see instructions)	0	3.01
4.00	Subtotal (sum of lines 1 through 3.01)	3,852,051	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,890,572	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	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)	3,890,572	19.00
20.00	Deductibles (exclude professional component)	294,376	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,596,196	22.00
23.00	Coinsurance	389	23.00
24.00	Subtotal (line 22 minus line 23)	3,595,807	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	6,482	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	4,213	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)	3,600,020	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.98	Recovery of accelerated depreciation.	0	29.98
29.99	Demonstration payment adjustment amount before sequestration	0	29.99
30.00	Subtotal (see instructions)	3,600,020	30.00
30.01	Sequestration adjustment (see instructions)	63,000	30.01
30.02	Demonstration payment adjustment amount after sequestration	0	30.02
30.03	Sequestration adjustment-PARHM		30.03
31.00	Interim payments	4,070,260	31.00
31.01	Interim payments-PARHM		31.01
32.00	Tentative settlement (for contractor use only)	0	32.00
32.01	Tentative settlement-PARHM (for contractor use only)		32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	-533,240	33.00
33.01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		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 04/01/2022 To 03/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 8/29/2023 9:20 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	5,067		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	5,067	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)	5,067	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)	5,067	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)	5,067	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)	5,067	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	5,067	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	5,067	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	5,067	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	5,067	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)	5,067	0	40.00
41.00	Interim payments	5,067	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G | Date/Time Prepared: 8/29/2023 9:20 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	45,737,459	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	42,437,641	0	0	0	4.00
5.00	Other receivable	262,185	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-38,908,744	0	0	0	6.00
7.00	Inventory	513,271	0	0	0	7.00
8.00	Prepaid expenses	620,517	0	0	0	8.00
9.00	Other current assets	25,000	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	50,687,329	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	-1,026,273	0	0	0	14.00
15.00	Buildings	35,375,964	0	0	0	15.00
16.00	Accumulated depreciation	-18,906,045	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	2,829,195	0	0	0	19.00
20.00	Accumulated depreciation	-2,010,198	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	11,883,149	0	0	0	23.00
24.00	Accumulated depreciation	-9,471,923	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	843,977	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	20,913,039	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,780,807	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,562,218	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	4,343,025	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	75,943,393	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,799,313	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,235,133	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	674,322	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	5,431,579	0	0	0	43.00
44.00	Other current liabilities	899,767	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	11,040,114	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	13,505,469	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	906,526	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	14,411,995	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,452,109	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	50,491,284				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)	50,491,284	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	75,943,393	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-1 | Date/Time Prepared: 8/29/2023 9:20 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		35,524,174		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		14,953,711				2.00
3.00	Total (sum of line 1 and line 2)		50,477,885		0		3.00
4.00	CHANGES IN RESTRICTED NET ASSETS	13,399		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)		13,399		0		10.00
11.00	Subtotal (line 3 plus line 10)		50,491,284		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)		50,491,284		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	CHANGES IN RESTRICTED NET ASSETS		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 04/01/2022 To 03/31/2023 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/29/2023 9:20 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	11,160,282		11,160,282	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	11,160,282		11,160,282	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	11,160,282		11,160,282	17.00
18.00	Ancillary services	11,814,220	121,330,876	133,145,096	18.00
19.00	Outpatient services	15,709	1,080,394	1,096,103	19.00
20.00	RURAL HEALTH CLINIC	0	3,357,099	3,357,099	20.00
20.01	RURAL HEALTH CLINIC II	0	1,482,594	1,482,594	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	861,709	7,824,898	8,686,607	27.00
27.01	OTHER (SPECIFY)	0	0	0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,851,920	135,075,861	158,927,781	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		38,433,695		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		38,433,695		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-1345 | Period: From 04/01/2022 To 03/31/2023 | Worksheet G-3 | Date/Time Prepared: 8/29/2023 9:20 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	158,927,781	1.00
2.00	Less contractual allowances and discounts on patients' accounts	110,602,457	2.00
3.00	Net patient revenues (line 1 minus line 2)	48,325,324	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	38,433,695	4.00
5.00	Net income from service to patients (line 3 minus line 4)	9,891,629	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	55,200	6.00
7.00	Income from investments	892,326	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	206,238	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	88,871	22.00
23.00	Governmental appropriations	0	23.00
24.00	PROPERTY TAX INCOME - GENERAL	272,643	24.00
24.01	MISC REVENUE	12,450	24.01
24.50	COVID-19 PHE Funding	3,700,444	24.50
25.00	Total other income (sum of lines 6-24)	5,228,172	25.00
26.00	Total (line 5 plus line 25)	15,119,801	26.00
27.00	GAIN/LOSS ON SALE OF ASSETS	166,090	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	166,090	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	14,953,711	29.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345
Component CCN: 14-3413
Period: From 04/01/2022 To 03/31/2023
Worksheet M-1
Date/Time Prepared: 8/29/2023 9:20 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	458,654	468,141	926,795	-212	926,583	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	510,466	35,243	545,709	-41	545,668	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	424,136	29,283	453,419	0	453,419	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,393,256	532,667	1,925,923	-253	1,925,670	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	27,423	27,423	0	27,423	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	27,423	27,423	0	27,423	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,393,256	560,090	1,953,346	-253	1,953,093	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	253	253	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	253	253	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3,862	3,862	0	3,862	29.00
30.00	Administrative Costs	0	26,108	26,108	0	26,108	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	29,970	29,970	0	29,970	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,393,256	590,060	1,983,316	0	1,983,316	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345 | Component CCN: 14-3413 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/29/2023 9:20 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	926,583		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	545,668		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	453,419		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,925,670		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	1,523	28,946		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	1,523	28,946		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,523	1,954,616		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	253		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	253		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	3,862		29.00
30.00	Administrative Costs	0	26,108		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	29,970		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,523	1,984,839		32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345 | Component CCN: 14-8608 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/29/2023 9:20 am

RHC II | 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	333,852	21,775	355,627	-211	355,416	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	275,804	17,989	293,793	-222	293,571	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	575,923	37,564	613,487	0	613,487	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,185,579	77,328	1,262,907	-433	1,262,474	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	25,964	25,964	0	25,964	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	25,964	25,964	0	25,964	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,185,579	103,292	1,288,871	-433	1,288,438	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	433	433	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	433	433	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	7,616	7,616	0	7,616	29.00
30.00	Administrative Costs	0	26,237	26,237	0	26,237	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	33,853	33,853	0	33,853	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,185,579	137,145	1,322,724	0	1,322,724	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 14-1345 | Component CCN: 14-8608 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-1 | Date/Time Prepared: 8/29/2023 9:20 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	355,416		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	293,571		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	613,487		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,262,474		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	5,897	31,861		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	5,897	31,861		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,897	1,294,335		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	433		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	433		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	7,616		29.00
30.00	Administrative Costs	0	26,237		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	33,853		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,897	1,328,621		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1345 Component CCN: 14-3413

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

Worksheet M-2 Date/Time Prepared: 8/29/2023 9:20 am

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	RHC I Cost: Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.20	2,291	4,200	5,040		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.49	12,753	2,100	5,229		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.69	15,044		10,269	15,044	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	1.90	544			544	6.00
7.00	Clinical Social Worker	0.95	113			113	7.00
7.01	Medical Nutrition Therapist (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)	6.54	15,701			15,701	8.00
9.00	Physician Services Under Agreements		243			243	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)					1,954,616	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					253	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,954,869	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999871	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					29,970	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,237,228	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,267,198	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,267,198	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,267,035	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					3,221,651	20.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 14-1345 | Component CCN: 14-8608 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-2 | Date/Time Prepared: 8/29/2023 9:20 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	1.31	2,649	4,200	5,502		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.87	3,336	2,100	3,927		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.18	5,985		9,429	9,429	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)	3.18	5,985			9,429	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)					1,294,335	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					433	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,294,768	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					0.999666	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					33,853	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					978,595	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,012,448	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					1,012,448	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					1,012,110	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					2,306,445	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 14-1345 Component CCN: 14-3413	Period: From 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/29/2023 9:20 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)		3,221,651	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)		2,918	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3,218,733	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		15,701	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		243	5.00
6.00	Total adjusted visits (line 4 plus line 5)		15,944	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		201.88	7.00

		Calculation of Limit (1)		
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	202.88	210.59	8.00
9.00	Rate for Program covered visits (see instructions)	201.88	201.88	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,449	474	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	292,524	95,691	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	388,215	16.00
16.01	Total program charges (see instructions)(from contractor's records)		433,218	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		32,454	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		29,083	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		260,007	16.04
16.05	Total program cost (see instructions)	0	289,090	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		34,123	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		72,761	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		289,090	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		206	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		289,296	22.00
23.00	Allowable bad debts (see instructions)		322	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		209	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
25.99	Demonstration payment adjustment amount before sequestration		0	25.99
26.00	Net reimbursable amount (see instructions)		289,505	26.00
26.01	Sequestration adjustment (see instructions)		5,067	26.01
26.02	Demonstration payment adjustment amount after sequestration		0	26.02
27.00	Interim payments		255,962	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)		28,476	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 04/01/2022 To 03/31/2023	Worksheet M-3 Date/Time Prepared: 8/29/2023 9:20 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)			2,306,445	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			11,389	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			2,295,056	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			9,429	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			9,429	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			243.40	7.00
		Calculation of Limit (1)			
		Rate Period 1 (04/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 03/31/2023)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	216.22	224.44		8.00
9.00	Rate for Program covered visits (see instructions)	216.22	224.44		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	1,707	558		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	369,088	125,238		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	494,326		16.00
16.01	Total program charges (see instructions)(from contractor's records)		537,355		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		62,521		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		57,515		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.)		306,093		16.04
16.05	Total program cost (see instructions)	0	363,608		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		54,195		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		83,441		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		363,608		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,905		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		365,513		22.00
23.00	Allowable bad debts (see instructions)		124		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		81		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		365,594		26.00
26.01	Sequestration adjustment (see instructions)		6,398		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		391,397		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)		-32,201		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 VACCINE COST

Provider CCN: 14-1345 | Component CCN: 14-3413 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,925,670	1,925,670	1,925,670	1,925,670	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000003	0.000125	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	6	241	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	236	1,287	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	242	1,528	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,954,616	1,954,616	1,954,616	1,954,616	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,267,035	1,267,035	1,267,035	1,267,035	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000124	0.000782	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	157	991	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	399	2,519	0	0	10.00
11.00	Total number of injections/infusions (from your records)	1	49	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	399.00	51.41	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	0	4	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	206	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		2,918	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		206	16.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 14-1345 | Component CCN: 14-8608 | Period: From 04/01/2022 To 03/31/2023 | Worksheet M-4 | Date/Time Prepared: 8/29/2023 9:20 am

Title XVIII | RHC II | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,262,474	1,262,474	1,262,474	1,262,474	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000050	0.000341	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	63	431	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	1,547	4,350	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	1,610	4,781	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1,294,335	1,294,335	1,294,335	1,294,335	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1,012,110	1,012,110	1,012,110	1,012,110	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.001244	0.003694	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	1,259	3,739	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,869	8,520	0	0	10.00
11.00	Total number of injections/infusions (from your records)	13	88	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	220.69	96.82	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	6	6	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	1,324	581	0	0	14.00

			COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
		1.00	2.00	
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		11,389	15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		1,905	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 04/01/2022 To 03/31/2023 | Worksheet M-5 | Date/Time Prepared: 8/29/2023 9:20 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		273,190	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		11/08/2022	17,228	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)		-17,228	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		255,962	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		28,476	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		284,438	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 04/01/2022 To 03/31/2023

Worksheet M-5

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

RHC II | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		379,974	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		11/08/2022	11,423	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)		11,423	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		391,397	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		32,201	6.02
7.00	Total Medicare program liability (see instructions)		359,196	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00