

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 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/24/2021 10:26 am
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PART I - COST REPORT STATUS			
Provider use only	1. ☒ Electronically prepared cost report 2. ☐ Manually prepared cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.		

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SSM SELECT REHAB ST LOUIS, LLC (26-3031) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) SCOTT ROMBERGER
 Officer or Administrator of Provider(s)

VICE PRESIDENT
 Title

(Dated when report is electronically signed.)
 Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	125,721	0	0	679,646	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	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	125,721	0	0	679,646	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 10:26 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1027 BELLEVUE AVENUE			PO Box:				1.00			
2.00	City: RICHMOND HEIGHTS			State: MO		Zip Code: 63117		County: ST LOUIS			
		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			SSM SELECT REHAB ST LOUIS, LLC	263031	41180	5	12/08/2009	N	P	O
4.00	Subprovider - IPF										3.00
5.00	Subprovider - IRF										4.00
6.00	Subprovider - (Other)										5.00
7.00	Swing Beds - SNF										6.00
8.00	Swing Beds - NF										7.00
9.00	Hospital-Based SNF										8.00
10.00	Hospital-Based NF										9.00
11.00	Hospital-Based OLTC										10.00
12.00	Hospital-Based HHA										11.00
13.00	Separately Certified ASC										12.00
14.00	Hospital-Based Hospice										13.00
15.00	Hospital-Based Health Clinic - RHC										14.00
16.00	Hospital-Based Health Clinic - FQHC										15.00
17.00	Hospital-Based (CMHC) I										16.00
18.00	Renal Dialysis										17.00
19.00	Other										18.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00	
21.00	Type of Control (see instructions)						4			21.00	
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 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 OMBdelineations 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.					3	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 10:26 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.	3,944	1,149	246	356	702		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.					1		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.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. 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	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 10:26 am	
			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
61.01	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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
64.00	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. 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
			0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/24/2021 10:26 am

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010					
	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00
			1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS					
	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	
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
	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.				Y	
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)				N	N 0

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			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N		80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N		81.00	
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N		85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N		87.00	
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00	
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	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	Y	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?	N		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)			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)			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.	N	N	N	N
				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 10:26 am
		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 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
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	286,353	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.	N		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.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0312	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/24/2021 10:26 am	
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: SELECT MEDICAL	Contractor's Name: NOVITAS SOLUTIONS INC		Contractor's Number: 12001		141.00	
142.00	Street: 4714 GETTYSBURG ROAD	PO Box:				142.00	
143.00	City: MECHANICSBURG	State: PA		Zip Code: 17055		143.00	
						1.00	
144.00 Are provider based physicians' costs included in Worksheet A?						Y	
						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.				Y		N
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		
						1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC	N		N		N	
						1.00	
Multicampus							
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						Y	
		Name		County		State	
		0		1.00		2.00	
				Zip Code		CBSA	
				3.00		4.00	
						FTE/Campus	
						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)	SSM RICHMOND HEIGHTS		ST LOUIS		MO	
						63117	
						41180	
						121.92	
166.01		SSM BRIDGETON		ST LOUIS		MO	
						63044	
						41180	
						279.21	
166.02		SSM LAKE ST. LOUIS		ST CHARLES		MO	
						63367	
						41180	
						103.31	
						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.						N	
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)							
168.01 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)							
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	
						Beginning	
						1.00	
						Ending	
						2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							
						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	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/24/2021 10:26 am	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date				
		1.00	2.00				
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				
		1.00	2.00				
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	11/24/2021	Y	11/24/2021		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)	N		N			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: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/24/2021 10:26 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				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.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				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.				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				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				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.				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.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				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.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				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.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	TOM		RIVES	41.00
42.00	Enter the employer/company name of the cost report preparer.	SELECT MEDICAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	717-972-8110		TRIVES@SELECTMEDICAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/24/2021 10:26 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.	SENIOR REIMBURSEMENT ANALYST		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: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 10:26 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	125	45,625	0.00	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)		125	45,625	0.00	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)		125	45,625	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		125			0	27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 10:26 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	16,921	3,944	39,101			1.00
2.00	HMO and other (see instructions)	8,348	702				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	0	0	0			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)	16,921	3,944	39,101			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)	16,921	3,944	39,101	0.00	504.44	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
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	504.44	27.00
28.00	Observation Bed Days		0	0			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/24/2021 10:26 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,397	295	3,007	1.00
2.00 HMO and other (see instructions)			590	52		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	1,397	295	3,007	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/24/2021 10:26 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	28,968,976	0	28,968,976	1,049,238.00	27.61
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	136,584	136,584	4,904.00	27.85
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative	214,500	0	214,500	1,430.00	150.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		0	0	0		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		0	0	0		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/24/2021 10:26 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	534,479	0	534,479	15,581.00	34.30	26.00
27.00	Administrative & General	5.00	4,493,700	-136,584	4,357,116	102,232.00	42.62	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	254,130	0	254,130	8,863.00	28.67	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	545,827	0	545,827	36,434.00	14.98	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	653,822	0	653,822	34,656.00	18.87	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	536,481	0	536,481	14,283.00	37.56	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	183,341	0	183,341	9,601.00	19.10	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/24/2021 10:26 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	28,968,976	0	28,968,976	1,049,238.00	27.61	1.00
2.00	Excluded area salaries (see instructions)	0	136,584	136,584	4,904.00	27.85	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28,968,976	-136,584	28,832,392	1,044,334.00	27.61	3.00
4.00	Subtotal other wages & related costs (see inst.)	214,500	0	214,500	1,430.00	150.00	4.00
5.00	Subtotal wage-related costs (see inst.)	0	0	0	0.00	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	29,183,476	-136,584	29,046,892	1,045,764.00	27.78	6.00
7.00	Total overhead cost (see instructions)	7,201,780	-136,584	7,065,196	221,650.00	31.88	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
11/24/2021 10:26 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	0	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	0	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/24/2021 10:26 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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		0	0	4,001,682	4,001,682	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		18,783,072	18,783,072	-15,084,857	3,698,215	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	534,479	187,852	722,331	61,399	783,730	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,493,700	3,530,560	8,024,260	10,838,314	18,862,574	5.00
7.00	00700	OPERATION OF PLANT	254,130	266,875	521,005	0	521,005	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	344,856	344,856	0	344,856	8.00
9.00	00900	HOUSEKEEPING	545,827	352,646	898,473	0	898,473	9.00
10.00	01000	DIETARY	653,822	1,401,807	2,055,629	-311,504	1,744,125	10.00
11.00	01100	CAFETERIA	0	0	0	311,504	311,504	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	536,481	112,528	649,009	0	649,009	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	183,341	41,747	225,088	0	225,088	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	12,369,285	3,963,456	16,332,741	1,110	16,333,851	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	108,733	108,733	0	108,733	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	217,324	217,324	0	217,324	54.00
60.00	06000	LABORATORY	2,518	869,508	872,026	0	872,026	60.00
65.00	06500	RESPIRATORY THERAPY	158,850	49,884	208,734	-1,110	207,624	65.00
66.00	06600	PHYSICAL THERAPY	3,907,058	681,465	4,588,523	0	4,588,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,610,154	430,565	3,040,719	0	3,040,719	67.00
68.00	06800	SPEECH PATHOLOGY	1,245,074	244,855	1,489,929	0	1,489,929	68.00
69.00	06900	ELECTROCARDIOLOGY	0	174,786	174,786	0	174,786	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	244,267	1,653,441	1,897,708	0	1,897,708	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,229,990	1,275,324	2,505,314	0	2,505,314	73.00
74.00	07400	RENAL DIALYSIS	0	556,919	556,919	0	556,919	74.00
75.01	07502	SSM OP CLINICS	0	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28,968,976	35,248,203	64,217,179	-183,462	64,033,717	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PROVIDER RELATIONS	0	0	0	183,462	183,462	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	28,968,976	35,248,203	64,217,179	0	64,217,179	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/24/2021 10:26 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	0	4,001,682	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-1,999,205	1,699,010	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	783,730	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-464,556	18,398,018	5.00
7.00	00700	OPERATION OF PLANT	0	521,005	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-998	343,858	8.00
9.00	00900	HOUSEKEEPING	-2	898,471	9.00
10.00	01000	DIETARY	-2,231	1,741,894	10.00
11.00	01100	CAFETERIA	-60,047	251,457	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	649,009	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,791	212,297	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	723,746	17,057,597	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-41,974	66,759	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-87,971	129,353	54.00
60.00	06000	LABORATORY	-186,176	685,850	60.00
65.00	06500	RESPIRATORY THERAPY	-115	207,509	65.00
66.00	06600	PHYSICAL THERAPY	0	4,588,523	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,040,719	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,489,929	68.00
69.00	06900	ELECTROCARDIOLOGY	-19,365	155,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,897,708	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,505,314	73.00
74.00	07400	RENAL DIALYSIS	0	556,919	74.00
75.01	07502	SSM OP CLINICS	32,167,279	32,167,279	75.01
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,015,594	94,049,311	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	PROVIDER RELATIONS	0	183,462	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	30,015,594	94,232,773	200.00

RECLASSIFICATIONS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/24/2021 10:26 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - FACILITY RENT					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	4,001,682		
	TOTALS		0	4,001,682		
1.00	B - EMPLOYEE BENEFITS					1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	61,399		
	TOTALS		0	61,399		
1.00	C - CAPITAL RECONCILIATION RECLASS					1.00
	ADMINISTRATIVE & GENERAL	5.00	0	11,083,175		
	TOTALS		0	11,083,175		
1.00	D - PROVIDER RELATIONS					1.00
	PROVIDER RELATIONS	194.00	136,584	46,878		
	TOTALS		136,584	46,878		
1.00	E - DIETARY RECLASS					1.00
	CAFETERIA	11.00	0	311,504		
	TOTALS		0	311,504		
1.00	F - SITTERS					1.00
	ADULTS & PEDIATRICS	30.00	0	1,110		
	TOTALS		0	1,110		
500.00	Grand Total: Increases		136,584	15,505,748		500.00

RECLASSIFICATIONS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/24/2021 10:26 am

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
1.00	A - FACILITY RENT					1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	4,001,682	10	
	TOTALS		0	4,001,682		
1.00	B - EMPLOYEE BENEFITS					1.00
	ADMINISTRATIVE & GENERAL	5.00	0	61,399	0	
	TOTALS		0	61,399		
1.00	C - CAPITAL RECONCILIATION RECLASS					1.00
	CAP REL COSTS-MVBLE EQUIP	2.00	0	11,083,175	12	
	TOTALS		0	11,083,175		
1.00	D - PROVIDER RELATIONS					1.00
	ADMINISTRATIVE & GENERAL	5.00	136,584	46,878	0	
	TOTALS		136,584	46,878		
1.00	E - DIETARY RECLASS					1.00
	DIETARY	10.00	0	311,504	0	
	TOTALS		0	311,504		
1.00	F - SITTERS					1.00
	RESPIRATORY THERAPY	65.00	0	1,110	0	
	TOTALS		0	1,110		
500.00	Grand Total: Decreases		136,584	15,505,748		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/24/2021 10:26 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00	
2.00	Land Improvements	0	0	0	0	0	2.00	
3.00	Buildings and Fixtures	0	0	0	0	0	3.00	
4.00	Building Improvements	19,931,626	1,978,179	0	1,978,179	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	14,850,135	1,039,942	0	1,039,942	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	34,781,761	3,018,121	0	3,018,121	0	8.00	
9.00	Reconciling Items	0	-3,833	0	-3,833	0	9.00	
10.00	Total (line 8 minus line 9)	34,781,761	3,021,954	0	3,021,954	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0				1.00	
2.00	Land Improvements	0	0				2.00	
3.00	Buildings and Fixtures	0	0				3.00	
4.00	Building Improvements	21,909,805	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	15,890,077	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	37,799,882	0				8.00	
9.00	Reconciling Items	-3,833	0				9.00	
10.00	Total (line 8 minus line 9)	37,803,715	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/24/2021 10:26 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,505,056	4,001,682	2,205,690	375,742	6,050,964	2.00
3.00	Total (sum of lines 1-2)	1,505,056	4,001,682	2,205,690	375,742	6,050,964	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	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,643,938	18,783,072				2.00
3.00	Total (sum of lines 1-2)	4,643,938	18,783,072				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/24/2021 10:26 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	21,909,805	0	21,909,805	0.579626	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,890,077	0	15,890,077	0.420374	0	2.00
3.00	Total (sum of lines 1-2)	37,799,882	0	37,799,882	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	0	4,001,682	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,686,480	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,686,480	4,001,682	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	0	4,001,682	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	25,061	-10,707,433	6,050,964	4,643,938	1,699,010	2.00
3.00	Total (sum of lines 1-2)	25,061	-10,707,433	6,050,964	4,643,938	5,700,692	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/24/2021 10:26 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-688,821			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	756,867			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL 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			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	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		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	OP SATELLITE CLINICS EXPENSE	A	31,004,598	SSM OP CLINICS	75.01	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/24/2021 10:26 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description			Basis/Code (2)	Amount	Cost Center	Line #
			1.00	2.00	3.00	4.00
						5.00
35.00	PHYSICIAN SERVICES EXPENSE	A		936,228	ADULTS & PEDIATRICS	30.00
38.00	BAD DEBT	A		0	ADMINISTRATIVE & GENERAL	5.00
40.00	MEDICAL RECORDS INCOME	B		-12,791	MEDICAL RECORDS & LIBRARY	16.00
41.00	CAFETERIA INCOME	B		-60,047	CAFETERIA	11.00
41.01	MINORITY INTEREST	A		-2,180,629	CAP REL COSTS-MVBLE EQUIP	2.00
41.02	MINORITY INTEREST	A		0	SSM OP CLINICS	75.01
41.03	MINORITY INTEREST	A		309,047	ADULTS & PEDIATRICS	30.00
41.04	OTHER PERSONNEL EXPENSE	A		-87,998	ADMINISTRATIVE & GENERAL	5.00
41.05	OTHER PERSONNEL EXPENSE	A		-32,225	SSM OP CLINICS	75.01
41.06	OTHER PERSONNEL EXPENSE	A		-1,023	ADULTS & PEDIATRICS	30.00
42.05	MARKETING	A		-39,450	SSM OP CLINICS	75.01
42.06	GIFTS	A		-1,233	SSM OP CLINICS	75.01
42.08	MARKETING	A		-12	ADULTS & PEDIATRICS	30.00
43.00	AGENCY COSTS NOT ACCRUED AT YE	A		113,083	ADULTS & PEDIATRICS	30.00
43.01	OTHER ADJUSTMENTS (SPECIFY)			0		0.00
	(3)					
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)			30,015,594		

(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.

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

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:

11/24/2021 10:26 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL	181,424	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	4,268,673	4,643,938	2.00
3.00	30.00	ADULTS & PEDIATRICS	HOME OFFICE A&P	98,295	43,051	3.00
3.01	75.01	SSM OP CLINICS	HOME OFFICE OP	4,175,504	2,939,915	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	ADMIN	1,557	2,850	3.02
3.03	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	19,597	20,595	3.03
3.04	9.00	HOUSEKEEPING	HOUSEKEEPING	12	14	3.04
3.05	10.00	DIETARY	DIETARY	158,383	160,614	3.05
3.06	50.00	OPERATING ROOM	OR	36,093	78,067	3.06
3.07	54.00	RADIOLOGY-DIAGNOSTIC	RADIOLOGY	125,291	213,262	3.07
3.08	60.00	LABORATORY	LAB	535,078	721,254	3.08
3.09	65.00	RESPIRATORY THERAPY	RT	9,680	9,795	3.09
3.10	66.00	PHYSICAL THERAPY	PT	89	89	3.10
3.11	67.00	OCCUPATIONAL THERAPY	OT	93	93	3.11
3.13	69.00	ELECTROCARDIOLOGY	EKG	52,748	72,113	3.13
3.14	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY	20,116	20,116	3.14
3.15	74.00	RENAL DIALYSIS	DIALYSIS	392	392	3.15
3.16	71.00	MEDICAL SUPPLIES CHARGED TO	CENTRAL SUPPLIES	8,516	8,516	3.16
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,691,541	8,934,674	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
	1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	B		0.00	SELECT PHYSICAL THERAPY OF ST LOUIS	51.00	6.00
7.00	B		0.00	SSM HEALTH CARE ST LOUIS	49.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-1

Date/Time Prepared:
11/24/2021 10:26 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	181,424	9		1.00
2.00	-375,265	0		2.00
3.00	55,244	0		3.00
3.01	1,235,589	0		3.01
3.02	-1,293	0		3.02
3.03	-998	0		3.03
3.04	-2	0		3.04
3.05	-2,231	0		3.05
3.06	-41,974	0		3.06
3.07	-87,971	0		3.07
3.08	-186,176	0		3.08
3.09	-115	0		3.09
3.10	0	0		3.10
3.11	0	0		3.11
3.13	-19,365	0		3.13
3.14	0	0		3.14
3.15	0	0		3.15
3.16	0	0		3.16
4.00	0	0		4.00
5.00	756,867			5.00

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

	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	HEALTHCARE		6.00
7.00	HEALTHCARE		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/24/2021 10:26 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	DR. A	186,568	122,606	63,962	211,500	677	1.00
2.00	30.00	DR. B	41,341	15,069	26,272	211,500	428	2.00
3.00	30.00	DR. C	446,625	253,408	193,217	211,500	834	3.00
4.00	30.00	DR. D	91,227	53,435	37,792	211,500	686	4.00
5.00	30.00	DR. E	22,456	20,820	1,636	211,500	26	5.00
6.00	30.00	DR. F	106,208	72,874	33,334	211,500	628	6.00
7.00	30.00	DR. G	69,461	42,195	27,266	211,500	484	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			963,886	580,407	383,479		3,763	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	DR. A	68,839	3,442	0	0	0	1.00
2.00	30.00	DR. B	43,520	2,176	0	0	0	2.00
3.00	30.00	DR. C	84,803	4,240	0	0	0	3.00
4.00	30.00	DR. D	69,754	3,488	0	0	0	4.00
5.00	30.00	DR. E	2,644	132	0	0	0	5.00
6.00	30.00	DR. F	63,857	3,193	0	0	0	6.00
7.00	30.00	DR. G	49,214	2,461	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			382,631	19,132	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	DR. A	0	68,839	0	122,606		1.00
2.00	30.00	DR. B	0	43,520	0	15,069		2.00
3.00	30.00	DR. C	0	84,803	108,414	361,822		3.00
4.00	30.00	DR. D	0	69,754	0	53,435		4.00
5.00	30.00	DR. E	0	2,644	0	20,820		5.00
6.00	30.00	DR. F	0	63,857	0	72,874		6.00
7.00	30.00	DR. G	0	49,214	0	42,195		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	382,631	108,414	688,821		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/24/2021 10:26 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,001,682	4,001,682			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,699,010		1,699,010		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	783,730	3,750	1,592	789,072	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,398,018	1,617,224	686,634	120,914	5.00
7.00	00700	OPERATION OF PLANT	521,005	94,182	39,987	7,052	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	343,858	56,380	23,937	0	8.00
9.00	00900	HOUSEKEEPING	898,471	12,340	5,239	15,147	9.00
10.00	01000	DIETARY	1,741,894	74,310	31,550	18,144	10.00
11.00	01100	CAFETERIA	251,457	79,389	33,706	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	649,009	67,254	28,554	14,888	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212,297	16,021	6,802	5,088	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	17,057,597	1,419,623	602,735	343,248	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	66,759	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	129,353	18,339	7,786	0	54.00
60.00	06000	LABORATORY	685,850	4,704	1,997	70	60.00
65.00	06500	RESPIRATORY THERAPY	207,509	0	0	4,408	65.00
66.00	06600	PHYSICAL THERAPY	4,588,523	212,805	90,352	108,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,040,719	168,969	71,740	72,434	67.00
68.00	06800	SPEECH PATHOLOGY	1,489,929	16,225	6,889	34,552	68.00
69.00	06900	ELECTROCARDIOLOGY	155,421	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,897,708	81,264	34,502	6,779	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,505,314	55,153	23,416	34,133	73.00
74.00	07400	RENAL DIALYSIS	556,919	0	0	0	74.00
75.01	07502	SSM OP CLINICS	32,167,279	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	94,049,311	3,997,932	1,697,418	785,282	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS	183,462	3,750	1,592	3,790	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	94,232,773	4,001,682	1,699,010	789,072	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3031

Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	20,822,790					5.00
7.00	00700	OPERATION OF PLANT	334,347	996,573				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	214,159	24,573	662,907			8.00
9.00	00900	HOUSEKEEPING	470,146	5,378	0	1,406,721		9.00
10.00	01000	DIETARY	942,062	32,388	0	47,134	2,887,482	10.00
11.00	01100	CAFETERIA	184,056	34,601	0	50,355	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	383,563	29,312	0	42,658	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	121,277	6,983	0	10,162	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,806,475	618,738	662,907	900,445	2,887,482	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	33,706	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	78,498	7,993	0	11,632	0	54.00
60.00	06000	LABORATORY	349,693	2,050	0	2,984	0	60.00
65.00	06500	RESPIRATORY THERAPY	106,994	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,524,473	92,750	0	134,979	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,693,311	73,645	0	107,175	0	67.00
68.00	06800	SPEECH PATHOLOGY	781,356	7,072	0	10,292	0	68.00
69.00	06900	ELECTROCARDIOLOGY	78,470	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,019,993	35,418	0	51,544	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,321,794	24,038	0	34,983	0	73.00
74.00	07400	RENAL DIALYSIS	281,179	0	0	0	0	74.00
75.01	07502	SSM OP CLINICS	0	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,725,552	994,939	662,907	1,404,343	2,887,482	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PROVIDER RELATIONS	97,238	1,634	0	2,378	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,822,790	996,573	662,907	1,406,721	2,887,482	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3031

Period:
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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	12.00	13.00	16.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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	633,564				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	11,858	0	1,227,096		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,905	0	0	386,535	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	381,207	0	1,227,096	172,035	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	398	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,147	54.00
60.00	06000	LABORATORY	0	0	0	20,678	60.00
65.00	06500	RESPIRATORY THERAPY	7,669	0	0	9,627	65.00
66.00	06600	PHYSICAL THERAPY	93,308	0	0	46,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	63,579	0	0	43,067	67.00
68.00	06800	SPEECH PATHOLOGY	38,445	0	0	44,655	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,621	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,655	0	0	11,717	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,999	0	0	20,218	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	2,574	74.00
75.01	07502	SSM OP CLINICS	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	630,625	0	1,227,096	386,535	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS	2,939	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	633,564	0	1,227,096	386,535	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	36,079,588	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	100,863	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	265,748	54.00
60.00	06000	LABORATORY	0	1,068,026	60.00
65.00	06500	RESPIRATORY THERAPY	0	336,207	65.00
66.00	06600	PHYSICAL THERAPY	0	7,892,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,334,639	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,429,415	68.00
69.00	06900	ELECTROCARDIOLOGY	0	236,512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,145,580	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,039,048	73.00
74.00	07400	RENAL DIALYSIS	0	840,672	74.00
75.01	07502	SSM OP CLINICS	0	32,167,279	75.01
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	93,935,990	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	PROVIDER RELATIONS	0	296,783	194.00
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	94,232,773	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3031

Period:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		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	3,750	1,592	5,342	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	293	1,617,224	686,634	2,304,151	5.00
7.00	00700	OPERATION OF PLANT	0	94,182	39,987	134,169	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	56,380	23,937	80,317	8.00
9.00	00900	HOUSEKEEPING	0	12,340	5,239	17,579	9.00
10.00	01000	DIETARY	0	74,310	31,550	105,860	10.00
11.00	01100	CAFETERIA	0	79,389	33,706	113,095	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	67,254	28,554	95,808	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,021	6,802	22,823	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,419,623	602,735	2,022,358	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,339	7,786	26,125	54.00
60.00	06000	LABORATORY	0	4,704	1,997	6,701	60.00
65.00	06500	RESPIRATORY THERAPY	6,071	0	0	6,071	65.00
66.00	06600	PHYSICAL THERAPY	0	212,805	90,352	303,157	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	168,969	71,740	240,709	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,225	6,889	23,114	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	165,601	81,264	34,502	281,367	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55,153	23,416	78,569	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	07502	SSM OP CLINICS	16,540	0	0	16,540	75.01
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	188,505	3,997,932	1,697,418	5,883,855	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS	0	3,750	1,592	5,342	194.00
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	188,505	4,001,682	1,699,010	5,889,197	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	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
5.00	00500	ADMINISTRATIVE & GENERAL	2,304,970					5.00
7.00	00700	OPERATION OF PLANT	37,010	171,227				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,706	4,222	108,245			8.00
9.00	00900	HOUSEKEEPING	52,043	924	0	70,649		9.00
10.00	01000	DIETARY	104,281	5,565	0	2,367	218,196	10.00
11.00	01100	CAFETERIA	20,374	5,945	0	2,529	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	42,458	5,036	0	2,142	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,425	1,200	0	510	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,085,522	106,310	108,245	45,223	218,196	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,731	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,689	1,373	0	584	0	54.00
60.00	06000	LABORATORY	38,709	352	0	150	0	60.00
65.00	06500	RESPIRATORY THERAPY	11,844	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	279,446	15,936	0	6,779	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	187,441	12,653	0	5,383	0	67.00
68.00	06800	SPEECH PATHOLOGY	86,492	1,215	0	517	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,686	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	112,908	6,085	0	2,589	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	146,316	4,130	0	1,757	0	73.00
74.00	07400	RENAL DIALYSIS	31,125	0	0	0	0	74.00
75.01	07502	SSM OP CLINICS	0	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,294,206	170,946	108,245	70,530	218,196	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PROVIDER RELATIONS	10,764	281	0	119	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,304,970	171,227	108,245	70,649	218,196	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3031

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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	
		11.00	12.00	13.00	16.00	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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
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	141,943				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	2,657	0	148,202		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,771	0	0	39,763	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	85,405	0	148,202	17,699	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	41	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,249	54.00
60.00	06000	LABORATORY	0	0	0	2,127	60.00
65.00	06500	RESPIRATORY THERAPY	1,718	0	0	990	65.00
66.00	06600	PHYSICAL THERAPY	20,905	0	0	4,814	66.00
67.00	06700	OCCUPATIONAL THERAPY	14,244	0	0	4,430	67.00
68.00	06800	SPEECH PATHOLOGY	8,613	0	0	4,593	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	270	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,491	0	0	1,205	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,481	0	0	2,080	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	265	74.00
75.01	07502	SSM OP CLINICS	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	141,285	0	148,202	39,763	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS	658	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	141,943	0	148,202	39,763	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3031

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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
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
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
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	3,839,481	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	3,772	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,020	54.00
60.00	06000	LABORATORY	0	48,039	60.00
65.00	06500	RESPIRATORY THERAPY	0	20,653	65.00
66.00	06600	PHYSICAL THERAPY	0	631,772	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	465,351	67.00
68.00	06800	SPEECH PATHOLOGY	0	124,778	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,956	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	405,691	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	237,564	73.00
74.00	07400	RENAL DIALYSIS	0	31,390	74.00
75.01	07502	SSM OP CLINICS	0	16,540	75.01
OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	93.99
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	5,872,007	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	PROVIDER RELATIONS	0	17,190	194.00
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	5,889,197	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

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Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	117,396					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		117,396				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	110	110	28,434,497			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	47,444	47,444	4,357,116	-20,822,790	41,242,704	5.00
7.00	00700	OPERATION OF PLANT	2,763	2,763	254,130	0	662,226	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,654	1,654	0	0	424,175	8.00
9.00	00900	HOUSEKEEPING	362	362	545,827	0	931,197	9.00
10.00	01000	DIETARY	2,180	2,180	653,822	0	1,865,898	10.00
11.00	01100	CAFETERIA	2,329	2,329	0	0	364,552	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,973	1,973	536,481	0	759,705	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	470	470	183,341	0	240,208	16.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,647	41,647	12,369,285	0	19,423,203	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	66,759	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	538	538	0	0	155,478	54.00
60.00	06000	LABORATORY	138	138	2,518	0	692,621	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	158,850	0	211,917	65.00
66.00	06600	PHYSICAL THERAPY	6,243	6,243	3,907,058	0	5,000,105	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,957	4,957	2,610,154	0	3,353,862	67.00
68.00	06800	SPEECH PATHOLOGY	476	476	1,245,074	0	1,547,595	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	155,421	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,384	2,384	244,267	0	2,020,253	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,618	1,618	1,229,990	0	2,618,016	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	556,919	74.00
75.01	07502	SSM OP CLINICS	0	0	0	-32,167,279	0	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,286	117,286	28,297,913	-52,990,069	41,050,110	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	PROVIDER RELATIONS	110	110	136,584	0	192,594	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,001,682	1,699,010	789,072		20,822,790	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	34.087039	14.472469	0.027751		0.504884	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			5,342		2,304,970	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000188		0.055888	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: 26-3031

Period:
From 07/01/2020
To 06/30/2021

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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	67,079				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,654	36,859			8.00
9.00	00900	HOUSEKEEPING	362	0	65,063		9.00
10.00	01000	DIETARY	2,180	0	2,180	36,859	10.00
11.00	01100	CAFETERIA	2,329	0	2,329	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,973	0	1,973	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	470	0	470	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,647	36,859	41,647	36,859	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	538	0	538	0	54.00
60.00	06000	LABORATORY	138	0	138	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	227	65.00
66.00	06600	PHYSICAL THERAPY	6,243	0	6,243	2,762	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,957	0	4,957	1,882	67.00
68.00	06800	SPEECH PATHOLOGY	476	0	476	1,138	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,384	0	2,384	197	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,618	0	1,618	592	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
75.01	07502	SSM OP CLINICS	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	66,969	36,859	64,953	36,859	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	PROVIDER RELATIONS	110	0	110	87	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	996,573	662,907	1,406,721	2,887,482	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.856706	17.984943	21.620906	78.338588	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	171,227	108,245	70,649	218,196	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.552617	2.936732	1.085855	5.919748	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: 26-3031

Period:
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Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (GROSSE REVENUE)	
			12.00	13.00	16.00	
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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
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	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	261		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	178,312,455	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	261	79,373,693	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	183,500	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	5,602,846	54.00
60.00	06000	LABORATORY	0	0	9,537,850	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,440,359	65.00
66.00	06600	PHYSICAL THERAPY	0	0	21,585,974	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	19,864,647	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	20,597,248	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,209,163	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,404,452	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,325,627	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,187,096	74.00
75.01	07502	SSM OP CLINICS	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS						
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	93.99
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	261	178,312,455	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	PROVIDER RELATIONS	0	0	0	194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,227,096	386,535	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	4,701.517241	0.002168	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	148,202	39,763	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	567.823755	0.000223	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: 26-3031

Period:
From 07/01/2020
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				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE		Total Costs	
						Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	36,079,588		36,079,588	108,414	36,188,002	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	100,863		100,863	0	100,863	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	265,748		265,748	0	265,748	54.00	
60.00	06000	LABORATORY	1,068,026		1,068,026	0	1,068,026	60.00	
65.00	06500	RESPIRATORY THERAPY	336,207	0	336,207	0	336,207	65.00	
66.00	06600	PHYSICAL THERAPY	7,892,413	0	7,892,413	0	7,892,413	66.00	
67.00	06700	OCCUPATIONAL THERAPY	5,334,639	0	5,334,639	0	5,334,639	67.00	
68.00	06800	SPEECH PATHOLOGY	2,429,415	0	2,429,415	0	2,429,415	68.00	
69.00	06900	ELECTROCARDIOLOGY	236,512		236,512	0	236,512	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,145,580		3,145,580	0	3,145,580	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,039,048		4,039,048	0	4,039,048	73.00	
74.00	07400	RENAL DIALYSIS	840,672		840,672	0	840,672	74.00	
75.01	07502	SSM OP CLINICS	32,167,279		32,167,279	0	32,167,279	75.01	
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99	
200.00		Subtotal (see instructions)	93,935,990	0	93,935,990	108,414	94,044,404	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	93,935,990	0	93,935,990	108,414	94,044,404	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3031

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			Title XVIII		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	79,373,639		79,373,639			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	183,500	0	183,500	0.549662	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,424,544	0	5,424,544	0.048990	0.000000	54.00
60.00	06000	LABORATORY	9,461,684	0	9,461,684	0.112879	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,438,488	0	4,438,488	0.075748	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	20,162,613	1,423,361	21,585,974	0.365627	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,423,282	1,441,365	19,864,647	0.268549	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	19,617,844	979,404	20,597,248	0.117949	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,146,574	0	1,146,574	0.206277	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,404,452	0	5,404,452	0.582035	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,325,627	0	9,325,627	0.433113	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,187,096	0	1,187,096	0.708175	0.000000	74.00
75.01	07502	SSM OP CLINICS	0	128,228,753	128,228,753	0.250859	0.000000	75.01
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
200.00		Subtotal (see instructions)	174,149,343	132,072,883	306,222,226			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	174,149,343	132,072,883	306,222,226			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3031

Period:
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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.549662			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.048990			54.00
60.00	06000 LABORATORY	0.112879			60.00
65.00	06500 RESPIRATORY THERAPY	0.075748			65.00
66.00	06600 PHYSICAL THERAPY	0.365627			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.268549			67.00
68.00	06800 SPEECH PATHOLOGY	0.117949			68.00
69.00	06900 ELECTROCARDIOLOGY	0.206277			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.582035			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.433113			73.00
74.00	07400 RENAL DIALYSIS	0.708175			74.00
75.01	07502 SSM OP CLINICS	0.250859			75.01
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
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: 26-3031

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				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	36,079,588		36,079,588	108,414	36,188,002	30.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	100,863		100,863	0	100,863	50.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	265,748		265,748	0	265,748	54.00	
60.00	06000	LABORATORY	1,068,026		1,068,026	0	1,068,026	60.00	
65.00	06500	RESPIRATORY THERAPY	336,207	0	336,207	0	336,207	65.00	
66.00	06600	PHYSICAL THERAPY	7,892,413	0	7,892,413	0	7,892,413	66.00	
67.00	06700	OCCUPATIONAL THERAPY	5,334,639	0	5,334,639	0	5,334,639	67.00	
68.00	06800	SPEECH PATHOLOGY	2,429,415	0	2,429,415	0	2,429,415	68.00	
69.00	06900	ELECTROCARDIOLOGY	236,512		236,512	0	236,512	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,145,580		3,145,580	0	3,145,580	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	4,039,048		4,039,048	0	4,039,048	73.00	
74.00	07400	RENAL DIALYSIS	840,672		840,672	0	840,672	74.00	
75.01	07502	SSM OP CLINICS	32,167,279		32,167,279	0	32,167,279	75.01	
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99	
200.00		Subtotal (see instructions)	93,935,990	0	93,935,990	108,414	94,044,404	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	93,935,990	0	93,935,990	108,414	94,044,404	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3031

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			Title XIX		Hospital	Cost		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	79,373,639		79,373,639			30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	183,500	0	183,500	0.549662	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,424,544	0	5,424,544	0.048990	0.000000	54.00
60.00	06000	LABORATORY	9,461,684	0	9,461,684	0.112879	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	4,438,488	0	4,438,488	0.075748	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	20,162,613	1,423,361	21,585,974	0.365627	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,423,282	1,441,365	19,864,647	0.268549	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	19,617,844	979,404	20,597,248	0.117949	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,146,574	0	1,146,574	0.206277	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,404,452	0	5,404,452	0.582035	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,325,627	0	9,325,627	0.433113	0.000000	73.00
74.00	07400	RENAL DIALYSIS	1,187,096	0	1,187,096	0.708175	0.000000	74.00
75.01	07502	SSM OP CLINICS	0	128,228,753	128,228,753	0.250859	0.000000	75.01
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000	93.99
200.00		Subtotal (see instructions)	174,149,343	132,072,883	306,222,226			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	174,149,343	132,072,883	306,222,226			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/24/2021 10:26 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
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
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400 RENAL DIALYSIS	0.000000			74.00
75.01	07502 SSM OP CLINICS	0.000000			75.01
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/24/2021 10:26 am

			Title XVIII		Hospital	PPS	
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	3,839,481	0	3,839,481	39,101	98.19	30.00
200.00	Total (lines 30 through 199)	3,839,481		3,839,481	39,101		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	16,921	1,661,473				30.00
200.00	Total (lines 30 through 199)	16,921	1,661,473				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/24/2021 10:26 am

				Title XVIII		Hospital	PPS	
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	3,772	183,500	0.020556	118,009	2,426	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,020	5,424,544	0.007009	2,372,320	16,628	54.00
60.00	06000	LABORATORY	48,039	9,461,684	0.005077	4,397,211	22,325	60.00
65.00	06500	RESPIRATORY THERAPY	20,653	4,438,488	0.004653	2,326,127	10,823	65.00
66.00	06600	PHYSICAL THERAPY	631,772	21,585,974	0.029268	8,947,041	261,862	66.00
67.00	06700	OCCUPATIONAL THERAPY	465,351	19,864,647	0.023426	8,124,272	190,319	67.00
68.00	06800	SPEECH PATHOLOGY	124,778	20,597,248	0.006058	7,170,736	43,440	68.00
69.00	06900	ELECTROCARDIOLOGY	8,956	1,146,574	0.007811	545,218	4,259	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	405,691	5,404,452	0.075066	2,154,567	161,735	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	237,564	9,325,627	0.025474	4,058,953	103,398	73.00
74.00	07400	RENAL DIALYSIS	31,390	1,187,096	0.026443	527,822	13,957	74.00
75.01	07502	SSM OP CLINICS	16,540	128,228,753	0.000129	0	0	75.01
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	2,032,526	226,848,587		40,742,276	831,172	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/24/2021 10:26 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	39,101	0.00	16,921		30.00	
200.00		Total (lines 30 through 199)			0	39,101		16,921		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: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/24/2021 10:26 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07502	SSM OP CLINICS	0	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
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: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/24/2021 10:26 am	
			Title XVIII		Hospital		PPS	
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	183,500	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,424,544	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,461,684	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,438,488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,585,974	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	19,864,647	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	20,597,248	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,146,574	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,404,452	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,325,627	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,187,096	0.000000	74.00
75.01	07502	SSM OP CLINICS	0	0	0	128,228,753	0.000000	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	226,848,587		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/24/2021 10:26 am	
				Title XVIII		Hospital		PPS	
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		118,009	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		2,372,320	0	0	0	54.00
60.00	06000	LABORATORY	0.000000		4,397,211	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		2,326,127	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		8,947,041	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		8,124,272	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		7,170,736	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		545,218	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		2,154,567	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		4,058,953	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000		527,822	0	0	0	74.00
75.01	07502	SSM OP CLINICS	0.000000		0	0	24,488	0	75.01
OUTPATIENT SERVICE COST CENTERS									
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		0	0	0	0	93.99
200.00		Total (lines 50 through 199)			40,742,276	0	24,488	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/24/2021 10:26 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.549662	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.048990	0	0	0	0	54.00
60.00	06000	LABORATORY	0.112879	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.075748	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.365627	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.268549	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.117949	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.206277	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.582035	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.433113	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.708175	0	0	0	0	74.00
75.01	07502	SSM OP CLINICS	0.250859	24,488	0	0	6,143	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Subtotal (see instructions)		24,488	0	0	6,143	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		24,488	0	0	6,143	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/24/2021 10:26 am

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.01	07502	SSM OP CLINICS	0	0		75.01
	OUTPATIENT SERVICE COST CENTERS					
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/24/2021 10:26 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	3,839,481	0	3,839,481	39,101	98.19	30.00
200.00	Total (lines 30 through 199)	3,839,481		3,839,481	39,101		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	3,944	387,261				30.00
200.00	Total (lines 30 through 199)	3,944	387,261				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/24/2021 10:26 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	3,772	183,500	0.020556	10,025	206	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,020	5,424,544	0.007009	582,572	4,083	54.00
60.00	06000	LABORATORY	48,039	9,461,684	0.005077	865,119	4,392	60.00
65.00	06500	RESPIRATORY THERAPY	20,653	4,438,488	0.004653	234,879	1,093	65.00
66.00	06600	PHYSICAL THERAPY	631,772	21,585,974	0.029268	1,921,239	56,231	66.00
67.00	06700	OCCUPATIONAL THERAPY	465,351	19,864,647	0.023426	1,759,930	41,228	67.00
68.00	06800	SPEECH PATHOLOGY	124,778	20,597,248	0.006058	1,873,415	11,349	68.00
69.00	06900	ELECTROCARDIOLOGY	8,956	1,146,574	0.007811	127,066	993	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	405,691	5,404,452	0.075066	635,128	47,677	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	237,564	9,325,627	0.025474	1,044,160	26,599	73.00
74.00	07400	RENAL DIALYSIS	31,390	1,187,096	0.026443	103,713	2,742	74.00
75.01	07502	SSM OP CLINICS	16,540	128,228,753	0.000129	0	0	75.01
	OUTPATIENT SERVICE COST CENTERS							
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.000000	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
200.00		Total (lines 50 through 199)	2,032,526	226,848,587		9,157,246	196,593	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/24/2021 10:26 am		
					Title XIX		Hospital		Cost		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	0	0	0	0	30.00	
200.00		Total (lines 30 through 199)		0	0	0	0	0	0	200.00	
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days		
					4.00	5.00	6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0	0	39,101	0.00	3,944		30.00	
200.00		Total (lines 30 through 199)			0	39,101		3,944		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: 26-3031		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/24/2021 10:26 am	
			Title XIX		Hospital		Cost	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.01	07502	SSM OP CLINICS	0	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93.99
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: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
Date/Time Prepared:
11/24/2021 10:26 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	183,500	0.000000	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,424,544	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	9,461,684	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	4,438,488	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,585,974	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	19,864,647	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	20,597,248	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,146,574	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	5,404,452	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,325,627	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,187,096	0.000000	74.00
75.01	07502	SSM OP CLINICS	0	0	0	128,228,753	0.000000	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
200.00		Total (lines 50 through 199)	0	0	0	226,848,587		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet D
Part IV
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Cost Center Description			Title XIX		Hospital		Cost	
			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	10,025	0	0	0	50.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	582,572	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	865,119	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	234,879	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,921,239	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,759,930	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,873,415	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	127,066	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	635,128	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	1,044,160	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	103,713	0	0	0	74.00
75.01	07502	SSM OP CLINICS	0.000000	0	0	0	0	75.01
OUTPATIENT SERVICE COST CENTERS								
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
200.00		Total (lines 50 through 199)		9,157,246	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/24/2021 10:26 am
		Title XVIII	Hospital	PPS
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)		39,101	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		39,101	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)		39,101	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)		0	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)		16,921	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		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		36,188,002	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)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		36,188,002	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)		36,188,002	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)		925.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		15,660,386	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)		15,660,386	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:

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Cost Center Description		Title XVIII		Hospital		PPS
		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)					10,650,737 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					26,311,123 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)					1,661,473 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					831,172 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,492,645 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,818,478 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

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Cost Center Description		Title XVIII		Hospital	PPS	
		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	3,839,481	36,188,002	0.106098	0	90.00
91.00	Nursing School cost	0	36,188,002	0.000000	0	91.00
92.00	Allied health cost	0	36,188,002	0.000000	0	92.00
93.00	All other Medical Education	0	36,188,002	0.000000	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/24/2021 10:26 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			39,101 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			39,101 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)			39,101 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)			0 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)			3,944 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			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			36,079,588 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)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			36,079,588 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)			36,079,588 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)			922.73 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			3,639,247 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)			3,639,247 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

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Date/Time Prepared:
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Cost Center Description		Title XIX		Hospital		Cost	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,467,111	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,106,358	49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/24/2021 10:26 am

Cost Center Description		Title XIX		Hospital		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	3,839,481	36,079,588	0.106417	0	0	90.00
91.00	Nursing School cost	0	36,079,588	0.000000	0	0	91.00
92.00	Allied health cost	0	36,079,588	0.000000	0	0	92.00
93.00	All other Medical Education	0	36,079,588	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/24/2021 10:26 am	
		Title XVIII	Hospital	PPS	
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		33,397,730		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.549662	118,009	64,865	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.048990	2,372,320	116,220	54.00
60.00	06000 LABORATORY	0.112879	4,397,211	496,353	60.00
65.00	06500 RESPIRATORY THERAPY	0.075748	2,326,127	176,199	65.00
66.00	06600 PHYSICAL THERAPY	0.365627	8,947,041	3,271,280	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.268549	8,124,272	2,181,765	67.00
68.00	06800 SPEECH PATHOLOGY	0.117949	7,170,736	845,781	68.00
69.00	06900 ELECTROCARDIOLOGY	0.206277	545,218	112,466	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.582035	2,154,567	1,254,033	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.433113	4,058,953	1,757,985	73.00
74.00	07400 RENAL DIALYSIS	0.708175	527,822	373,790	74.00
75.01	07502 SSM OP CLINICS	0.250859	0	0	75.01
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		40,742,276	10,650,737	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		40,742,276		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/24/2021 10:26 am	
Cost Center Description		Title XIX	Hospital	Cost	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		7,944,710		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.549662	10,025	5,510	50.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.048990	582,572	28,540	54.00
60.00	06000 LABORATORY	0.112879	865,119	97,654	60.00
65.00	06500 RESPIRATORY THERAPY	0.075748	234,879	17,792	65.00
66.00	06600 PHYSICAL THERAPY	0.365627	1,921,239	702,457	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.268549	1,759,930	472,627	67.00
68.00	06800 SPEECH PATHOLOGY	0.117949	1,873,415	220,967	68.00
69.00	06900 ELECTROCARDIOLOGY	0.206277	127,066	26,211	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.582035	635,128	369,667	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.433113	1,044,160	452,239	73.00
74.00	07400 RENAL DIALYSIS	0.708175	103,713	73,447	74.00
75.01	07502 SSM OP CLINICS	0.250859	0	0	75.01
OUTPATIENT SERVICE COST CENTERS					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	93.99
200.00	Total (sum of lines 50 through 94 and 96 through 98)		9,157,246	2,467,111	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)		9,157,246		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/24/2021 10:26 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		6,143	2.00
3.00	OPPS payments		13,597	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)		0	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)		0	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)		13,597	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		2,804	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)		10,793	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		10,793	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		10,793	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		10,793	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		10,793	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		10,793	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/24/2021 10:26 am

		Title XVIII		Hospital		PPS	
		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		29,293,455		10,793	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	12/31/2020	1,372,200		0	3.01	
3.02		06/21/2021	431,100		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		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)		1,803,300		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)		31,096,755		10,793	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		125,721		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		31,222,476		10,793	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		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part III Date/Time Prepared: 11/24/2021 10:26 am
		Title XVIII	Hospital	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		28,967,157	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0417	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		1,769,893	3.00
4.00	Outlier Payments		897,798	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		107.126027	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		31,634,848	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		31,634,848	17.00
18.00	Primary payer payments		48,296	18.00
19.00	Subtotal (line 17 less line 18).		31,586,552	19.00
20.00	Deductibles		259,748	20.00
21.00	Subtotal (line 19 minus line 20)		31,326,804	21.00
22.00	Coinsurance		188,543	22.00
23.00	Subtotal (line 21 minus line 22)		31,138,261	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		129,561	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		84,215	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		45,882	26.00
27.00	Subtotal (sum of lines 23 and 25)		31,222,476	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		31,222,476	32.00
32.01	Sequestration adjustment (see instructions)		0	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		31,096,755	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		125,721	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		897,798	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3031	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/24/2021 10:26 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	6,106,358		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	6,106,358	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)	6,106,358	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	7,870,132		8.00
9.00	Ancillary service charges	9,157,246	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)	17,027,378	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)	17,027,378	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	10,921,020	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	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)	6,106,358	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	6,106,358	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	6,106,358	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	6,106,358	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	6,106,358	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	6,106,358	0	40.00
41.00	Interim payments	5,426,712	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	679,646	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: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:

11/24/2021 10:26 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	4,549	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	6,560,592	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	31,624	0	0	0	8.00
9.00	Other current assets	314,448	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)	6,911,213	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	21,909,805	0	0	0	15.00
16.00	Accumulated depreciation	-13,915,701	0	0	0	16.00
17.00	Leasehold improvements	113,364	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	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	15,893,911	0	0	0	23.00
24.00	Accumulated depreciation	-10,510,404	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	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,490,975	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	84,375	0	0	0	32.00
33.00	Due from owners/officers	65,648,324	0	0	0	33.00
34.00	Other assets	44,578,289	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	110,310,988	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	130,713,176	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,815,175	0	0	0	37.00
38.00	Salaries, wages, and fees payable	12,660,592	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,839,666	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	8,015,339	0	0	0	43.00
44.00	Other current liabilities	-2,646	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	29,328,126	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	26,596,093	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	687,463	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	27,283,556	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	56,611,682	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	74,101,494				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)	74,101,494	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	130,713,176	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/24/2021 10:26 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		88,775,057		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		15,646,934				2.00
3.00	Total (sum of line 1 and line 2)		104,421,991		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	FUND BALANCE RECON	-30,320,497		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)		-30,320,497		0		10.00
11.00	Subtotal (line 3 plus line 10)		74,101,494		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)		74,101,494		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	FUND BALANCE RECON		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: 26-3031

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/24/2021 10:26 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	79,373,693		79,373,693	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)	79,373,693		79,373,693	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)	79,373,693		79,373,693	17.00
18.00	Ancillary services	95,094,630	128,228,753	223,323,383	18.00
19.00	Outpatient services	0	3,844,130	3,844,130	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	174,468,323	132,072,883	306,541,206	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		64,217,179		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)		64,217,179		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-3031

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/24/2021 10:26 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	306,541,206	1.00
2.00	Less contractual allowances and discounts on patients' accounts	198,132,598	2.00
3.00	Net patient revenues (line 1 minus line 2)	108,408,608	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	64,217,179	4.00
5.00	Net income from service to patients (line 3 minus line 4)	44,191,429	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	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	60,047	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	12,791	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	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	10	24.00
24.01	ACCUTE THERAPISTS	0	24.01
24.02	HOME HEALTH	0	24.02
24.03	THERAPISTS TO ST JOES	0	24.03
24.04	MARK UP	0	24.04
24.05	SSM PHYSICIAN REVENUE	649,564	24.05
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	722,412	25.00
26.00	Total (line 5 plus line 25)	44,913,841	26.00
27.00	OP CLINIC EXPENSE	28,064,683	27.00
27.01	SSM PHYSICIAN EXPENSE	1,202,224	27.01
27.02	INTERCOMPANY INTEREST	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	29,266,907	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	15,646,934	29.00