

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: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 10:06 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 11/30/2021	Time: 10:06 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (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 RANKEN JORDAN (26-3303) 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) JOHN CLAGG

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

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	0	0	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	0	0	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 26-3303		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 10:06 am				
1.00		2.00		3.00		4.00						
Hospital and Hospital Health Care Complex Address:												
1.00	Street: 11365 DORSETT RD			PO Box:				1.00				
2.00	City: MARYLAND HEIGHTS			State: MO		Zip Code: 63043		County: ST. LOUIS				
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
								V	XVIII			
								XIX				
Hospital and Hospital-Based Component Identification:												
3.00	Hospital			RANKEN JORDAN	263303	41180	7	07/31/2002	N	T	O	3.00
4.00	Subprovider - IPF											4.00
5.00	Subprovider - IRF											5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC											15.00
16.00	Hospital-Based Health Clinic - FQHC											16.00
17.00	Hospital-Based (CMHC) I											17.00
18.00	Renal Dialysis											18.00
19.00	Other											19.00
							From:	To:				
							1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020		06/30/2021		20.00	
21.00	Type of Control (see instructions)						2				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: 26-3303

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural St	Date of Geogra	
					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
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
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
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
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		
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.					N		
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		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3303		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 10:06 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
61.20	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
							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
62.01	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
63.00	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	
			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
						0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 26-3303

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
	1.00	2.00	3.00	4.00	5.00			
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
			1.00	2.00	3.00			
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010								
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	5.00			
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00		
					1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS								
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N		70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 10:06 am	
			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.	Y	Y	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.	Y	Y	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.	Y	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.	Y	Y	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)	N		106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00	
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 10:06 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		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	137,772	0	0118.01
		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.	Y	5.00	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		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 26-3303		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 10:06 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:	Contractor's Name:		Contractor's Number:						
142.00	Street:	PO Box:								
143.00	City:	State:		Zip Code:						
								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.								N	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.									146.00
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	N	157.00		
158.00	SUBPROVIDER							158.00		
159.00	SNF	N	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	N	161.00		
								1.00		
165.00	Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus			
		0	1.00	2.00	3.00	4.00	5.00			
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00		
								1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act										
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								0.00	169.00
								Beginning	Ending	
								1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)									170.00
								1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 10:06 am
			Y/N 1.00	Date 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 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 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.	N		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 1.00	Date 2.00	Y/N 3.00 Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		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		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		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/30/2021 10:06 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	
		1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Y	Y	21.00
				1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)				
Capital Related Cost				
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
Interest Expense				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
Purchased Services				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N		33.00
Provider-Based Physicians				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
Home Office Costs				
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer	CLIFTONLARSONALLEN LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4446	KEVIN.WELLEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/30/2021 10:06 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.	DIRECTOR	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: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 10:06 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	60	21,900	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)		60	21,900	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)		60	21,900	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)		60			0	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)		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: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 10:06 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)	0	4,801	16,390			1.00
2.00	HMO and other (see instructions)	0	8,716				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)	0	4,801	16,390			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	4,801	16,390	0.00	313.03	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	313.03	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: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 10:06 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	0	46	272	1.00
2.00 HMO and other (see instructions)			0	139		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	0	46	272	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

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3303

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

Worksheet A

Date/Time Prepared:
11/30/2021 10:06 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		5,097,404	5,097,404	0	5,097,404 1.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0 3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,255,807	3,671,192	4,926,999	0	4,926,999 4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,043,570	4,845,322	7,888,892	0	7,888,892 5.00
7.00	00700	OPERATION OF PLANT	690,482	903,742	1,594,224	-14,466	1,579,758 7.00
10.00	01000	DIETARY	393,391	139,197	532,588	0	532,588 10.00
13.00	01300	NURSING ADMINISTRATION	1,021,779	97,136	1,118,915	0	1,118,915 13.00
15.00	01500	PHARMACY	866,306	1,479,805	2,346,111	-1,389,859	956,252 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	225,219	36,120	261,339	0	261,339 16.00
17.00	01700	SOCIAL SERVICE	471,342	81,570	552,912	0	552,912 17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,534,092	1,238,806	11,772,898	14,466	11,787,364 30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	178,794	178,794	0	178,794 54.00
60.00	06000	LABORATORY	0	110,947	110,947	0	110,947 60.00
65.00	06500	RESPIRATORY THERAPY	1,817,467	602,327	2,419,794	0	2,419,794 65.00
66.00	06600	PHYSICAL THERAPY	2,192,320	274,455	2,466,775	0	2,466,775 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	512,117	512,117	0	512,117 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,389,859	1,389,859 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	0 113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	22,511,775	19,268,934	41,780,709	0	41,780,709 118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MARKETING	685,213	464,134	1,149,347	0	1,149,347 194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	23,196,988	19,733,068	42,930,056	0	42,930,056 200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet A
Date/Time Prepared:
11/30/2021 10:06 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	-1,553,683	3,543,721	1.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-224,305	4,702,694	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-190,741	7,698,151	5.00
7.00	00700	OPERATION OF PLANT	0	1,579,758	7.00
10.00	01000	DIETARY	-2	532,586	10.00
13.00	01300	NURSING ADMINISTRATION	0	1,118,915	13.00
15.00	01500	PHARMACY	0	956,252	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,016	253,323	16.00
17.00	01700	SOCIAL SERVICE	0	552,912	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,760,393	9,026,971	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	178,794	54.00
60.00	06000	LABORATORY	0	110,947	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,419,794	65.00
66.00	06600	PHYSICAL THERAPY	0	2,466,775	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	512,117	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,389,859	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-4,737,140	37,043,569	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	MARKETING	0	1,149,347	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-4,737,140	38,192,916	200.00

RECLASSIFICATIONS

Provider CCN: 26-3303

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 10:06 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	452,807		1.00
	TOTALS		0	452,807		
	C - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,389,859		1.00
	TOTALS		0	1,389,859		
	D - LAUNDRY & LINEN EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	0	14,466		1.00
	TOTALS		0	14,466		
500.00	Grand Total: Increases		0	1,857,132		500.00

RECLASSIFICATIONS

Provider CCN: 26-3303

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

Worksheet A-6

Date/Time Prepared:
11/30/2021 10:06 am

	Decreases						11/03/2022 10:55 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	B - PROPERTY INSURANCE						1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	452,807	12		
	TOTALS		0	452,807			
1.00	C - DRUGS CHARGED TO PATIENTS						1.00
	PHARMACY	15.00	0	1,389,859	0		
	TOTALS		0	1,389,859			
1.00	D - LAUNDRY & LINEN EXPENSE						1.00
	OPERATION OF PLANT	7.00	0	14,466	0		
	TOTALS		0	14,466			
500.00	Grand Total: Decreases		0	1,857,132			500.00

500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3303

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

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,359,177	0	0	0	0	1.00
2.00	Land Improvements	1,195,191	1,046,036	0	1,046,036	0	2.00
3.00	Buildings and Fixtures	54,021,826	3,350	0	3,350	0	3.00
4.00	Building Improvements	1,112,143	0	0	0	0	4.00
5.00	Fixed Equipment	16,484,415	254,016	0	254,016	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	75,172,752	1,303,402	0	1,303,402	0	8.00
9.00	Reconciling Items	0	-43,986	0	-43,986	0	9.00
10.00	Total (line 8 minus line 9)	75,172,752	1,347,388	0	1,347,388	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,359,177	0				1.00
2.00	Land Improvements	2,241,227	0				2.00
3.00	Buildings and Fixtures	54,025,176	0				3.00
4.00	Building Improvements	1,112,143	0				4.00
5.00	Fixed Equipment	16,738,431	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	76,476,154	0				8.00
9.00	Reconciling Items	-43,986	0				9.00
10.00	Total (line 8 minus line 9)	76,520,140	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 10:06 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	3,090,914	0	1,553,683	452,807	0	1.00
3.00	Total (sum of lines 1-2)	3,090,914	0	1,553,683	452,807	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	5,097,404				1.00
3.00	Total (sum of lines 1-2)	0	5,097,404				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 10:06 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	76,476,154	0	76,476,154	1.000000	452,807	1.00
3.00	Total (sum of lines 1-2)	76,476,154	0	76,476,154	1.000000	452,807	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	452,807	3,090,914	0	1.00
3.00	Total (sum of lines 1-2)	0	0	452,807	3,090,914	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	452,807	0	0	3,543,721	1.00
3.00	Total (sum of lines 1-2)	0	452,807	0	0	3,543,721	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-3303

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 10:06 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		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,553,683	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	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	-2,757,966			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		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	B	-7,997	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	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	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISC INCOME VARIOUS	B	-24,003	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISC INCOME INSURANCE REBATES	B	-123,169	ADMINISTRATIVE & GENERAL	5.00	0	33.01
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 26-3303

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 10:06 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	
35.00	PROVIDER-BASED PHYSICIAN BENEFITS	A	-224,224	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.00
36.00	LOBBYING EXPENSE - EMPLOYEE BENEFITS	A	-81	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
37.00	LOBBYING EXPENSE - A&G	A	-26,826	ADMINISTRATIVE & GENERAL	5.00	0	37.00
37.01	LOBBYING EXPENSE - DIETARY	A	-2	DIETARY	10.00	0	37.01
37.02	LOBBYING EXPENSE - MEDICAL RECORDS	A	-19	MEDICAL RECORDS & LIBRARY	16.00	0	37.02
37.03	LOBBYING EXPENSE - ADULTS & PEDS	A	-1,427	ADULTS & PEDIATRICS	30.00	0	37.03
38.00	BAD DEBT EXPENSE	A	-16,743	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	MARKETING - NURSING	A	-1,000	ADULTS & PEDIATRICS	30.00	0	39.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,737,140				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 26-3303

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 10:06 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	5.00	ADMINISTRATIVE & GENERAL	LEGAL FEES	227,003	227,003	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			227,003	227,003	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	Name	Percentage of Ownership	
	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	E	THOMAS MINOGUE	0.00	THOMPSON COBURN	0.00	6.00
7.00			0.00		0.00	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: 26-3303

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

Worksheet A-8-1

Date/Time Prepared:
11/30/2021 10:06 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	0	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	0			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	LAW FIRM		6.00
7.00			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: 26-3303

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

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 10:06 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	3,403,104	2,747,878	655,226	197,500	6,515	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	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			3,403,104	2,747,878	655,226		6,515	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	618,612	30,931	0	0	137,772	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	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			618,612	30,931	0	0	137,772	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	26,526	645,138	10,088	2,757,966		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		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			26,526	645,138	10,088	2,757,966		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3303

Period:
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
				BLDG & FIXT				
			0	1.00	4.00	4A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,543,721	3,543,721				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,702,694	32,690	4,735,384			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,698,151	551,954	752,346	9,002,451	9,002,451	5.00
7.00	00700	OPERATION OF PLANT	1,579,758	446,210	170,682	2,196,650	677,456	7.00
10.00	01000	DIETARY	532,586	67,842	97,243	697,671	215,165	10.00
13.00	01300	NURSING ADMINISTRATION	1,118,915	111,140	252,576	1,482,631	457,249	13.00
15.00	01500	PHARMACY	956,252	0	214,144	1,170,396	360,955	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	253,323	24,858	55,672	333,853	102,962	16.00
17.00	01700	SOCIAL SERVICE	552,912	22,658	116,512	692,082	213,441	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	9,026,971	1,881,860	1,915,643	12,824,474	3,955,113	30.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	178,794	0	0	178,794	55,141	54.00
60.00	06000	LABORATORY	110,947	0	0	110,947	34,216	60.00
65.00	06500	RESPIRATORY THERAPY	2,419,794	2,357	449,263	2,871,414	885,556	65.00
66.00	06600	PHYSICAL THERAPY	2,466,775	276,894	541,924	3,285,593	1,013,290	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	512,117	46,861	0	558,978	172,391	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,389,859	39,002	0	1,428,861	440,666	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	24,884	0	24,884	7,674	90.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,043,569	3,529,210	4,566,005	36,859,679	8,591,275	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MARKETING	1,149,347	14,511	169,379	1,333,237	411,176	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,192,916	3,543,721	4,735,384	38,192,916	9,002,451	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3303

Period:
From 07/01/2020
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Cost Center Description		OPERATION OF PLANT	DIETARY	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		7.00	10.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	2,874,106				7.00
10.00	01000	DIETARY	77,594	990,430			10.00
13.00	01300	NURSING ADMINISTRATION	127,117	0	2,066,997		13.00
15.00	01500	PHARMACY	0	0	0	1,531,351	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,431	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	25,915	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,152,390	990,430	2,041,350	0	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	2,696	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	316,699	0	25,647	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,597	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	44,609	0	0	1,531,351	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	28,461	0	0	0	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,857,509	990,430	2,066,997	1,531,351	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MARKETING	16,597	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)	2,874,106	990,430	2,066,997	1,531,351	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 26-3303

Period:
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	931,438				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	931,438	23,360,441	0	23,360,441	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	233,935	0	233,935	54.00
60.00	06000	LABORATORY	0	145,163	0	145,163	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,759,666	0	3,759,666	65.00
66.00	06600	PHYSICAL THERAPY	0	4,641,229	0	4,641,229	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	784,966	0	784,966	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,445,487	0	3,445,487	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	61,019	0	61,019	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	931,438	36,431,906	0	36,431,906	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MARKETING	0	1,761,010	0	1,761,010	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	931,438	38,192,916	0	38,192,916	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3303

Period:
From 07/01/2020
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT				
		0	1.00	2A	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	32,690	32,690	32,690	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	49,759	551,954	601,713	5,192	5.00
7.00	00700	OPERATION OF PLANT	688	446,210	446,898	1,178	7.00
10.00	01000	DIETARY	0	67,842	67,842	671	10.00
13.00	01300	NURSING ADMINISTRATION	0	111,140	111,140	1,743	13.00
15.00	01500	PHARMACY	0	0	0	1,478	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,858	24,858	384	16.00
17.00	01700	SOCIAL SERVICE	500	22,658	23,158	804	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	144,425	1,881,860	2,026,285	13,230	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,717	54.00
60.00	06000	LABORATORY	0	0	0	2,307	60.00
65.00	06500	RESPIRATORY THERAPY	161,772	2,357	164,129	3,101	65.00
66.00	06600	PHYSICAL THERAPY	0	276,894	276,894	3,740	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	46,861	46,861	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	39,002	39,002	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	24,884	24,884	0	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	357,144	3,529,210	3,886,354	31,521	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MARKETING	0	14,511	14,511	1,169	194.00
200.00		Cross Foot Adjustments		0	0		200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	357,144	3,543,721	3,900,865	32,690	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3303

Period:
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Cost Center Description			OPERATION OF PLANT	DIETARY	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			7.00	10.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	493,747					7.00
10.00	01000	DIETARY	13,330	96,348				10.00
13.00	01300	NURSING ADMINISTRATION	21,838	0	165,546			13.00
15.00	01500	PHARMACY	0	0	0	25,812		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,884	0	0	0	37,067	16.00
17.00	01700	SOCIAL SERVICE	4,452	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	369,763	96,348	163,492	0	37,067	30.00
ANCILLARY SERVICE COST CENTERS								
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	463	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	54,406	0	2,054	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,208	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,663	0	0	25,812	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,889	0	0	0	0	90.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	490,896	96,348	165,546	25,812	37,067	118.00
NONREIMBURSABLE COST CENTERS								
194.00	07950	MARKETING	2,851	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	493,747	96,348	165,546	25,812	37,067	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 26-3303

Period:
From 07/01/2020
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
10.00	01000	DIETARY					10.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	42,803				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,803	3,015,628	0	3,015,628	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,717	0	3,717	54.00
60.00	06000	LABORATORY	0	2,307	0	2,307	60.00
65.00	06500	RESPIRATORY THERAPY	0	227,393	0	227,393	65.00
66.00	06600	PHYSICAL THERAPY	0	405,405	0	405,405	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	67,691	0	67,691	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	102,184	0	102,184	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	30,290	0	30,290	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	42,803	3,854,615	0	3,854,615	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MARKETING	0	46,250	0	46,250	194.00
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	42,803	3,900,865	0	3,900,865	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 26-3303

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (DIRECT NRSNG HRS)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	135,289				1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,248	19,156,689			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,072	3,043,570	-9,002,451	29,190,465	5.00
7.00	00700	OPERATION OF PLANT	17,035	690,482	0	2,196,650	7.00
10.00	01000	DIETARY	2,590	393,391	0	697,671	10.00
13.00	01300	NURSING ADMINISTRATION	4,243	1,021,779	0	1,482,631	13.00
15.00	01500	PHARMACY	0	866,306	0	1,170,396	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	949	225,219	0	333,853	16.00
17.00	01700	SOCIAL SERVICE	865	471,342	0	692,082	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	71,844	7,749,600	0	12,824,474	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	178,794	54.00
60.00	06000	LABORATORY	0	0	0	110,947	60.00
65.00	06500	RESPIRATORY THERAPY	90	1,817,467	0	2,871,414	65.00
66.00	06600	PHYSICAL THERAPY	10,571	2,192,320	0	3,285,593	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,789	0	0	558,978	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,489	0	0	1,428,861	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	950	0	0	24,884	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,735	18,471,476	-9,002,451	27,857,228	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MARKETING	554	685,213	0	1,333,237	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,543,721	4,735,384		9,002,451	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	26.193711	0.247192		0.308404	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		32,690		606,905	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.001706		0.020791	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: 26-3303

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		DIETARY (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HOURS)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		10.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
10.00	01000	DIETARY	49,170				10.00
13.00	01300	NURSING ADMINISTRATION	0	200,842			13.00
15.00	01500	PHARMACY	0	0	1,389,859		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	8,001	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	49,170	198,350	0	8,001	30.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,492	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,389,859	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,170	200,842	1,389,859	8,001	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	MARKETING	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	990,430	2,066,997	1,531,351	465,246	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	20.142973	10.291657	1.101803	58.148481	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	96,348	165,546	25,812	37,067	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.959487	0.824260	0.018572	4.632796	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: 26-3303

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

				Title XVIII	Hospital	TEFRA		
	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	23,360,441		23,360,441	0	0	30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,935		233,935	0	0	54.00
60.00	06000	LABORATORY	145,163		145,163	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,759,666	0	3,759,666	0	0	65.00
66.00	06600	PHYSICAL THERAPY	4,641,229	0	4,641,229	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	784,966		784,966	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,445,487		3,445,487	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	61,019		61,019	0	0	90.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	36,431,906	0	36,431,906	0	0	200.00
201.00		Less Observation Beds	0		0			201.00
202.00		Total (see instructions)	36,431,906	0	36,431,906	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
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			Title XVIII		Hospital	TEFRA		
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	49,170,000		49,170,000			30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	821,897	0	821,897	0.284628	0.284628	54.00
60.00	06000	LABORATORY	283,705	0	283,705	0.511669	0.511669	60.00
65.00	06500	RESPIRATORY THERAPY	12,659,203	0	12,659,203	0.296991	0.296991	65.00
66.00	06600	PHYSICAL THERAPY	5,326,335	1,714,541	7,040,876	0.659183	0.659183	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,246,109	0	1,246,109	0.629934	0.629934	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,072,619	0	2,072,619	1.662383	1.662383	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	99,090	99,090	0.615794	0.615794	90.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	71,579,868	1,813,631	73,393,499			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	71,579,868	1,813,631	73,393,499			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 10:06 am
				Title XVIII	Hospital	TEFRA
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		30.00		
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00		
60.00	06000	LABORATORY	0.000000			
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00		
66.00	06600	PHYSICAL THERAPY	0.000000			
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	90.00		
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		113.00		
200.00		Subtotal (see instructions)				
201.00		Less Observation Beds				
202.00		Total (see instructions)				

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3303

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

				Title XIX		Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,360,441		23,360,441	10,088	23,370,529	30.00	
	ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,935		233,935	0	233,935	54.00	
60.00	06000	LABORATORY	145,163		145,163	0	145,163	60.00	
65.00	06500	RESPIRATORY THERAPY	3,759,666	0	3,759,666	0	3,759,666	65.00	
66.00	06600	PHYSICAL THERAPY	4,641,229	0	4,641,229	0	4,641,229	66.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	784,966		784,966	0	784,966	71.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	3,445,487		3,445,487	0	3,445,487	73.00	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	61,019		61,019	0	61,019	90.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	36,431,906	0	36,431,906	10,088	36,441,994	200.00	
201.00		Less Observation Beds	0		0		0	201.00	
202.00		Total (see instructions)	36,431,906	0	36,431,906	10,088	36,441,994	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
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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	49,170,000		49,170,000			30.00
	ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	821,897	0	821,897	0.284628	0.000000	54.00
60.00	06000	LABORATORY	283,705	0	283,705	0.511669	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	12,659,203	0	12,659,203	0.296991	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	5,326,335	1,714,541	7,040,876	0.659183	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,246,109	0	1,246,109	0.629934	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,072,619	0	2,072,619	1.662383	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	99,090	99,090	0.615794	0.000000	90.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	71,579,868	1,813,631	73,393,499			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	71,579,868	1,813,631	73,393,499			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 10:06 am
				Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio			
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		30.00		
	ANCILLARY SERVICE COST CENTERS					
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		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00		
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	90.00		
	SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE		113.00		
200.00		Subtotal (see instructions)		200.00		
201.00		Less Observation Beds		201.00		
202.00		Total (see instructions)		202.00		

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 26-3303

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

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)	TEFRA
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS		3,015,628	0	3,015,628	16,390	183.99	30.00
200.00	Total (lines 30 through 199)		3,015,628		3,015,628	16,390		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		0	0				
200.00	Total (lines 30 through 199)		0	0				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 26-3303

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

Cost Center Description			Title XVIII		Hospital	TEFRA	
			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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,717	821,897	0.004522	0	0 54.00
60.00	06000	LABORATORY	2,307	283,705	0.008132	0	0 60.00
65.00	06500	RESPIRATORY THERAPY	227,393	12,659,203	0.017963	0	0 65.00
66.00	06600	PHYSICAL THERAPY	405,405	7,040,876	0.057579	0	0 66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	67,691	1,246,109	0.054322	0	0 71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	102,184	2,072,619	0.049302	0	0 73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	30,290	99,090	0.305682	0	0 90.00
200.00		Total (lines 50 through 199)	838,987	24,223,499		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 26-3303		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/30/2021 10:06 am	
					Title XVIII		Hospital		TEFRA	
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	30.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	16,390	0.00	0	30.00		
200.00		Total (lines 30 through 199)		0	16,390		0	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: 26-3303

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII		Hospital		TEFRA	
		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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-3303

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 10:06 am

				Title XVIII		Hospital	TEFRA	
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)	
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	821,897	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	283,705	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	12,659,203	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	7,040,876	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,246,109	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,072,619	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	99,090	0.000000	90.00
200.00		Total (lines 50 through 199)	0	0	0	24,223,499		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 26-3303

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

Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 10:06 am

			Title XVIII		Hospital	TEFRA		
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							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 26-3303		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/30/2021 10:06 am	
				Title XIX		Hospital		Cost	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Charges		Costs	
						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									
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.284628	0	0	0	0	54.00
60.00	06000	LABORATORY		0.511669	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY		0.296991	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.659183	0	114,306	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.629934	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		1.662383	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.615794	0	0	0	0	90.00
200.00		Subtotal (see instructions)			0	114,306	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			0	114,306	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 26-3303		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/30/2021 10:06 am	
				Title XIX		Hospital		Cost	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
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	75,349	0					66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0					73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0					90.00
200.00		Subtotal (see instructions)	75,349	0					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	75,349	0					202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-3303

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

Worksheet D-1

Date/Time Prepared:

11/30/2021 10:06 am

Title XVIII		Hospital	TEFRA	
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)		16,390	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,390	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)		16,390	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)		0	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)		23,360,441	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)		23,360,441	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)		23,360,441	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,425.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		0	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)		0	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-3303

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 10:06 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	TEFRA
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					0	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					39,542.82	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: 26-3303

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 10:06 am

Cost Center Description		Title XVIII		Hospital		TEFRA	
		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	3,015,628	23,360,441	0.129091	0	0	90.00
91.00	Nursing School cost	0	23,360,441	0.000000	0	0	91.00
92.00	Allied health cost	0	23,360,441	0.000000	0	0	92.00
93.00	All other Medical Education	0	23,360,441	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 10:06 am
Cost Center Description		Title XIX	Hospital	Cost
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			16,390 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			16,390 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)			16,390 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)			4,801 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)			23,360,441 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)			23,360,441 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)			23,360,441 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,425.29 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			6,842,817 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)			6,842,817 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 26-3303

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 10:06 am

Cost Center Description		Title XIX		Hospital		Cost
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	
		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)					2,846,331 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					9,689,148 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: 26-3303

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

Worksheet D-1

Date/Time Prepared:
11/30/2021 10:06 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	3,015,628	23,360,441	0.129091	0	0	90.00
91.00	Nursing School cost	0	23,360,441	0.000000	0	0	91.00
92.00	Allied health cost	0	23,360,441	0.000000	0	0	92.00
93.00	All other Medical Education	0	23,360,441	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 10:06 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		14,403,000		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.284628	138,111	39,310	54.00
60.00	06000 LABORATORY	0.511669	57,822	29,586	60.00
65.00	06500 RESPIRATORY THERAPY	0.296991	3,539,670	1,051,250	65.00
66.00	06600 PHYSICAL THERAPY	0.659183	819,080	539,924	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.629934	278,364	175,351	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1.662383	608,109	1,010,910	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.615794	0	0	90.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,441,156	2,846,331	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		5,441,156		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part I Date/Time Prepared: 11/30/2021 10:06 am
		Title XVIII	Hospital	TEFRA
			1.00	
PART I - MEDICARE PART A SERVICES - TEFRA				
1.00	Inpatient hospital services (see instructions)			0 1.00
1.01	Nursing and allied health managed care payment (see instructions)			0 1.01
2.00	Organ acquisition			0 2.00
3.00	Cost of physicians' services in a teaching hospital (see instructions)			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			0 4.00
5.00	Primary payer payments			0 5.00
6.00	Subtotal (line 4 less line 5).			0 6.00
7.00	Deductibles			0 7.00
8.00	Subtotal (line 6 minus line 7)			0 8.00
9.00	Coinsurance			0 9.00
10.00	Subtotal (line 8 minus line 9)			0 10.00
11.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 11.00
12.00	Adjusted reimbursable bad debts (see instructions)			0 12.00
13.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 13.00
14.00	Subtotal (sum of lines 10 and 12)			0 14.00
15.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 15.00
16.00	DO NOT USE THIS LINE			0 16.00
17.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 17.00
17.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 17.50
17.99	Demonstration payment adjustment amount before sequestration			0 17.99
18.00	Total amount payable to the provider (see instructions)			0 18.00
18.01	Sequestration adjustment (see instructions)			0 18.01
18.02	Demonstration payment adjustment amount after sequestration			0 18.02
19.00	Interim payments			0 19.00
20.00	Tentative settlement (for contractor use only)			0 20.00
21.00	Balance due provider/program (line 18 minus lines 18.01, 18.02, 19, and 20)			0 21.00
22.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 22.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 26-3303	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/30/2021 10:06 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	9,689,148		1.00
2.00	Medical and other services		75,349	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	9,689,148	75,349	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)	9,689,148	75,349	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	14,403,000		8.00
9.00	Ancillary service charges	5,441,156	114,306	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)	19,844,156	114,306	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)	19,844,156	114,306	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	10,155,008	38,957	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)	9,689,148	75,349	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	9,689,148	75,349	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)	9,689,148	75,349	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	9,689,148	75,349	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	9,689,148	75,349	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	9,689,148	75,349	40.00
41.00	Interim payments	9,689,148	75,349	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

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

Provider CCN: 26-3303

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

Worksheet G

Date/Time Prepared:
11/30/2021 10:06 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	2,070,974	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	7,502,711	0	0	0	4.00
5.00	Other receivable	300,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	379,716	0	0	0	7.00
8.00	Prepaid expenses	1,205,081	0	0	0	8.00
9.00	Other current assets	875,416	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)	12,333,898	0	0	0	11.00
FIXED ASSETS						
12.00	Land	2,359,177	0	0	0	12.00
13.00	Land improvements	2,241,227	0	0	0	13.00
14.00	Accumulated depreciation	-656,110	0	0	0	14.00
15.00	Buildings	54,025,176	0	0	0	15.00
16.00	Accumulated depreciation	-12,451,599	0	0	0	16.00
17.00	Leasehold improvements	1,112,143	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	16,738,431	0	0	0	19.00
20.00	Accumulated depreciation	-12,777,124	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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	43,986	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	50,635,307	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	75,229,460	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	75,229,460	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	138,198,665	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	489,064	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,034,378	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	670,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	605,416	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,798,858	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	34,462,006	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,532,366	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	40,994,372	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	45,793,230	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	92,405,435				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)	92,405,435	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	138,198,665	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 26-3303

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

Worksheet G-1

Date/Time Prepared:
11/30/2021 10:06 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		68,570,989		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		24,704,917				2.00
3.00	Total (sum of line 1 and line 2)		93,275,906		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		93,275,906		0		11.00
12.00	DECREASE IN RESTRICTED ASSETS	870,471		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)		870,471		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		92,405,435		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	DECREASE IN RESTRICTED ASSETS		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: 26-3303

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

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	49,170,000		49,170,000	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)	49,170,000		49,170,000	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)	49,170,000		49,170,000	17.00
18.00	Ancillary services	22,409,868	1,714,541	24,124,409	18.00
19.00	Outpatient services	0	99,090	99,090	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	PROFESSIONAL FEES	1,142,373	0	1,142,373	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	72,722,241	1,813,631	74,535,872	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,930,056		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)		42,930,056		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 26-3303

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

Worksheet G-3

Date/Time Prepared:
11/30/2021 10:06 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,535,872	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,583,129	2.00
3.00	Net patient revenues (line 1 minus line 2)	52,952,743	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,930,056	4.00
5.00	Net income from service to patients (line 3 minus line 4)	10,022,687	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	4,384,743	6.00
7.00	Income from investments	1,939,400	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	0	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	7,997	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	UNREALIZED GAINS	8,145,239	24.00
24.01	MISC INCOME	196,738	24.01
24.02	GRANTS - USDA	8,113	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	14,682,230	25.00
26.00	Total (line 5 plus line 25)	24,704,917	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	24,704,917	29.00