

CALCULATION OF REIMBURSEMENT
SETTLEMENT

PROVIDER CCN:

11-0177

PERIOD:

FROM: 04/01/2021
TO: 03/31/2022WORKSHEET E,
PART ACheck Applicable Box: Hospital PARHM Demonstration Chart Model

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS

1

1	DRG amounts other than outlier payments			1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	15,990,135		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	16,479,520		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			1.04
2	Outlier payments for discharges (see instructions)			2
2.01	Outlier reconciliation amount			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	1,196,865		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	2,361,374		2.04
3	Managed care simulated payments	37,660,651		3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	284.97		4
	Indirect Medical Education Adjustment Calculation for Hospitals			
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)			5
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)			5.01
6	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			6
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			6.26
7	MMA §422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(1)			7
7.01	ACA §5503 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011, see instructions.			7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			7.02
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			8
8.01	The amount of increase if the hospital was awarded FTE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under §5506 of ACA. (see instructions)			8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			8.21
9	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, 9 plus lines 8.01 through 8.27 (see instructions)			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	1.63		10
11	FTE count for residents in dental and podiatric programs			11
12	Current year allowable FTE (see instructions)			12
13	Total allowable FTE count for the prior year			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997; otherwise enter zero.			14
15	Sum of lines 12 through 14 divided by 3			15
16	Adjustment for residents in initial years of the program (see instructions)			16
17	Adjustment for residents displaced by program or hospital closure			17
18	Adjusted rolling average FTE count			18
19	Current year resident to bed ratio (line 18 divided by line 4)			19
20	Prior year resident to bed ratio (see instructions)			20
21	Enter the lesser of lines 19 or 20 (see instructions)			21
22	IME payment adjustment (see instructions)			22
22.01	IME payment adjustment - Managed Care (see instructions)			22.01
	Indirect Medical Education Adjustment for the Add-on for §422 of the MMA			
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105(f)(1)(iv)(C).			23
24	IME FTE resident count over cap (see instructions)	1.63		24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			25
26	Resident to bed ratio (divide line 25 by line 4)			26
27	IME payments adjustment factor (see instructions)			27
28	IME add-on adjustment amount (see instructions)			28
28.01	IME add-on adjustment amount - Managed Care (see instructions)			28.01
29	Total IME payment (sum of lines 22 and 28)			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			29.01
	Disproportionate Share Adjustment			
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.0838		30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.2158		31
32	Sum of lines 30 and 31	0.2996		32
33	Allowable disproportionate share percentage (see instructions)	0.1393		33
34	Disproportionate share adjustment (see instructions)	1,130,756		34
	Uncompensated Care Payment Adjustment			
35	Total uncompensated care amount (see instructions)	8,290,014,521	7,192,008,710	35
35.01	Factor 3 (see instructions)	0.000619750	0.000671647	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	5,137,738	4,830,492	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	2,575,908	2,408,628	35.03
35.04	Pro rata share of the MDH's UCP, including supplemental UCP (see instructions)			35.04
35.05	Pro rata share of the SCH's UCP, including supplemental UCP (see instructions)			35.05
36	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		4,984,536	36

CALCULATION OF REIMBURSEMENT
SETTLEMENT

PROVIDER CCN:

PERIOD:

WORKSHEET E,
PART A

11-0177

FROM: 04/01/2021
TO: 03/31/2022Check Applicable Box: Hospital PARHM Demonstration Chart Model

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.)

1

Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)

40	Total Medicare discharges (see instructions)		40
41	Total ESRD Medicare discharges (see instructions)		41
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		42
43	Total Medicare ESRD inpatient days (see instructions)		43
44	Ratio of average length of stay to one week (line 43 divided by 7 days)		44
45	Average weekly cost for dialysis treatments (see instructions)		45
46	Total additional payment (line 45 times line 44 times line 41.01)		46
47	Subtotal (see instructions)	42,143,186	47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)		48
49	Total payment for inpatient operating costs (see instructions)	42,143,186	49
50	Payment for inpatient program capital (from Wkst. L, Pt. I, or Pt. II, as applicable)	2,972,081	50
52	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)		52
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions).		52
53	Nursing and allied health managed care payment		53
54	Special add-on payments for new technologies	166,516	54
54.01	Islet isolation add-on payment		54.01
55	Net organ acquisition cost (Wkst. D-4, Pt. III, col. 1, line 69)		55
55.01	Cellular therapy acquisition cost (see instructions)		55.01
56	Cost of physicians' services in a teaching hospital (see instructions)		56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35)		57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)		58
59	Total (sum of amounts on lines 49 through 58)	45,281,783	59
60	Primary payer payments	59,227	60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	45,222,556	61
62	Deductibles billed to program beneficiaries	2,977,664	62
63	Coinsurance billed to program beneficiaries	370,672	63
64	Allowable bad debts (see instructions)	800,707	64
65	Adjusted reimbursable bad debts (see instructions)	520,460	65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	210,526	66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	42,394,680	67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)		68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)		69
70	Other adjustments (specify) (see instructions)	410	70
70.5	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		70.5
70.87	Demonstration payment adjustment amount before sequestration		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.9	HSP bonus payment HVBP adjustment amount (see instructions)		70.9
70.91	HSP bonus payment HRR adjustment amount (see instructions)		70.91
70.92	Bundled Model 1 discount amount (see instructions)		70.92
70.93	HVBP payment adjustment amount (see instructions)	3,339	70.93
70.94	HRR adjustment amount (see instructions)	(159,737)	70.94
70.95	Recovery of accelerated depreciation		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy)		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy)		70.97
70.99	HAC adjustment amount (see instructions)		70.99
71	Amount due provider (see instructions)	42,238,692	71
71.01	Sequestration adjustment (see instructions)		71.01
71.02	Demonstration payment adjustment amount after sequestration		71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs		71.03
72	Interim payments	40,834,102	72
72.01	Interim payments-PARHM or CHART		72.01
73	Tentative settlement (for contractor use only)		73
73.01	Tentative settlement-PARHM or CHART (for contractor use only)		73.01
74	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)	1,404,590	74
74.01	Balance due provider/program-PARHM or CHART (see instructions)		74.01
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	1,673,364	75

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD:	WORKSHEET E,
	11-0177	FROM: 04/01/2021 TO: 03/31/2022	PART A

Check Applicable Box: Hospital PARHM Demonstration Chart Model

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS (Cont.) 1

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		90
91	Capital outlier from Wkst. L, Pt. I, line 2	370,412	91
92	Operating outlier reconciliation adjustment amount (see instructions)		92
93	Capital outlier reconciliation adjustment amount (see instructions)		93
94	The rate used to calculate the time value of money (see instructions)		94
95	Time value of money for operating expenses (see instructions)		95
96	Time value of money for capital related expenses (see instructions) 96		96
	HSP Bonus Payment Amount	Prior to 10/1	On or After 10/1
100	HSP bonus amount (see instructions)		100
	HVBP Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1
101	HVBP adjustment factor (see instructions)		101
102	HVBP Adjustment amount for HSP Bonus Payment (see instructions)		102
	HRR Adjustment for HSP Bonus Payment	Prior to 10/1	On or After 10/1
103	HRR Adjustment factor (see instructions)		103
104	HRR Adjustment amount for HSP Bonus Payment (see instructions)		104
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment		
200	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.		200
	Cost Reimbursement		
201	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)		201
202	Medicare discharges (see instructions)		202
203	Case-mix adjustment factor (see instructions)		203
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)		
204	Medicare target amount		204
205	Case-mix adjusted target amount (line 203 times line 204)		205
206	Medicare inpatient routine cost cap (line 202 times line 205)		206
	Adjustment to Medicare Part A Inpatient Reimbursement		
207	Program reimbursement under the §410A Demonstration (see instructions)		207
208	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)		208
209	Adjustment to Medicare IPPS payments (see instructions)		209
210	Reserved for future use		210
211	Total adjustment to Medicare IPPS payments (see instructions)		211
	Comparison of PPS versus Cost Reimbursement		
212	Total adjustment to Medicare Part A IPPS payments (from line 211)		212
213	Low-volume adjustment (see instructions)		213
218	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)		218

CALCULATION OF REIMBURSEMENT
SETTLEMENT

PROVIDER CCN:

PERIOD:

WORKSHEET E,
PART B

11-0177

FROM: 04/01/2021
TO: 03/31/2022

Check	<input checked="" type="checkbox"/> Hospital	<input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> Chart Model
Applicable	<input type="checkbox"/> IPF	<input type="checkbox"/> SNF	
Boxes:	<input type="checkbox"/> IRF	<input type="checkbox"/> PARHM Demonstration	
PART B - MEDICAL AND OTHER HEALTH SERVICES			1
1	Medical and other services (see instructions)	4,037	1
2	Medical and other services reimbursed under OPPS (see instructions)	16,618,111	2
3	OPPS payments	14,153,676	3
4	Outlier payment (see instructions)	8,528	4
4.01	Outlier reconciliation amount (see instructions)		4.01
5	Enter the hospital specific payment to cost ratio (see instructions)		5
6	Line 2 times line 5		6
7	Sum of lines 3, 4, and 4.01, divided by line 6		7
8	Transitional corridor payment (see instructions)		8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9
10	Organ acquisition		10
11	Total cost (sum of lines 1 and 10) (see instructions)	4,037	11
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12	Ancillary service charges	97,775	12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)		13
14	Total reasonable charges (sum of lines 12 and 13)	97,775	14
Customary charges			
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15
16	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)		16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)		17
18	Total customary charges (see instructions)	97,775	18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	93,738	19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		20
21	Lesser of cost or charges (see instructions)	4,037	21
22	Interns and residents (see instructions)		22
23	Cost of physicians' services in a teaching hospital (see instructions)		23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8, and 9)	14,162,204	24
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance amounts (see instructions)		25
26	Deductibles and Coinsurance amounts relating to amount on line 24 (see instructions)	2,603,376	26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	11,562,865	27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)		28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)		29
30	Subtotal (sum of lines 27 through 29)	11,562,865	30
31	Primary payer payments	3,030	31
32	Subtotal (line 30 minus line 31)	11,559,835	32
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33	Composite rate ESRD (from Wkst. I-5, line 11)		33
34	Allowable bad debts (see instructions)	396,891	34
35	Adjusted reimbursable bad debts (see instructions)	257,979	35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	206,853	36
37	Subtotal (see instructions)	11,817,814	37
38	MSP-LCC reconciliation amount from PS&R	275	38
39	Other adjustments (specify) (see instructions)		39
39.5	Pioneer ACO demonstration payment adjustment (see instructions)		39.5
39.97	Demonstration payment adjustment amount before sequestration		39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		39.98
39.99	Recovery of Accelerated depreciation		39.99
40	Subtotal (see instructions)	11,817,539	40
40.01	Sequestration adjustment (see instructions)		40.01
40.02	Demonstration payment adjustment amount after sequestration		40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41	Interim payments	11,857,564	41
41.01	Interim payments-PARHM or CHART		41.01
42	Tentative settlement (for contractors use only)		42
42.01	Tentative settlement-PARHM or CHART (for contractors use only)		42.01
43	Balance due provider/program (see instructions)	(40,025)	43
43.01	Balance due provider/program-PARHM or CHART (see instructions)		43.01
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	182,418	44

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: 11-0177	PERIOD: FROM: 04/01/2021 TO: 03/31/2022	WORKSHEET E, PART B
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Check	<input checked="" type="checkbox"/> Hospital	<input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> Chart Model
Applicable	<input type="checkbox"/> IPF	<input type="checkbox"/> SNF	
Boxes:	<input type="checkbox"/> IRF	<input type="checkbox"/> PARHM Demonstration	

PART B - MEDICAL AND OTHER HEALTH SERVICES	1
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TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)	8,528	90
91	Outlier reconciliation adjustment amount (see instructions)		91
92	The rate used to calculate the Time Value of Money		92
93	Time Value of Money (see instructions)		93
94	Total (sum of lines 90 and 93)		94

CALCULATION OF REIMBURSEMENT
SETTLEMENT

PROVIDER CCN:

PERIOD:

WORKSHEET E,
PART B

11-0177

FROM: 04/01/2021
TO: 03/31/2022

Check	<input type="checkbox"/> Hospital	<input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> Chart Model
Applicable	<input type="checkbox"/> IPF	<input type="checkbox"/> SNF	
Boxes:	<input checked="" type="checkbox"/> IRF	<input type="checkbox"/> PARHM Demonstration	
PART B - MEDICAL AND OTHER HEALTH SERVICES			1
1	Medical and other services (see instructions)	16	1
2	Medical and other services reimbursed under OPPS (see instructions)	500	2
3	OPPS payments	642	3
4	Outlier payment (see instructions)		4
4.01	Outlier reconciliation amount (see instructions)		4.01
5	Enter the hospital specific payment to cost ratio (see instructions)		5
6	Line 2 times line 5		6
7	Sum of lines 3, 4, and 4.01, divided by line 6		7
8	Transitional corridor payment (see instructions)		8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		9
10	Organ acquisition		10
11	Total cost (sum of lines 1 and 10) (see instructions)	16	11
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12	Ancillary service charges	385	12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)		13
14	Total reasonable charges (sum of lines 12 and 13)	385	14
Customary charges			
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15
16	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)		16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)		17
18	Total customary charges (see instructions)	385	18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	369	19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		20
21	Lesser of cost or charges (see instructions)	16	21
22	Interns and residents (see instructions)		22
23	Cost of physicians' services in a teaching hospital (see instructions)		23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8, and 9)	642	24
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25	Deductibles and coinsurance amounts (see instructions)		25
26	Deductibles and Coinsurance amounts relating to amount on line 24 (see instructions)	121	26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	537	27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)		28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)		29
30	Subtotal (sum of lines 27 through 29)	537	30
31	Primary payer payments		31
32	Subtotal (line 30 minus line 31)	537	32
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33	Composite rate ESRD (from Wkst. I-5, line 11)		33
34	Allowable bad debts (see instructions)		34
35	Adjusted reimbursable bad debts (see instructions)		35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)		36
37	Subtotal (see instructions)	537	37
38	MSP-LCC reconciliation amount from PS&R		38
39	Other adjustments (specify) (see instructions)		39
39.5	Pioneer ACO demonstration payment adjustment (see instructions)		39.5
39.97	Demonstration payment adjustment amount before sequestration		39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		39.98
39.99	Recovery of Accelerated depreciation		39.99
40	Subtotal (see instructions)	537	40
40.01	Sequestration adjustment (see instructions)		40.01
40.02	Demonstration payment adjustment amount after sequestration		40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41	Interim payments	598	41
41.01	Interim payments-PARHM or CHART		41.01
42	Tentative settlement (for contractors use only)		42
42.01	Tentative settlement-PARHM or CHART (for contractors use only)		42.01
43	Balance due provider/program (see instructions)	(61)	43
43.01	Balance due provider/program-PARHM or CHART (see instructions)		43.01
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		44

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: 11-0177	PERIOD: FROM: 04/01/2021 TO: 03/31/2022	WORKSHEET E, PART B
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Check	<input checked="" type="checkbox"/> Hospital	<input type="checkbox"/> Subprovider (Other)	<input type="checkbox"/> Chart Model
Applicable	<input type="checkbox"/> IPF	<input type="checkbox"/> SNF	
Boxes:	<input type="checkbox"/> IRF	<input type="checkbox"/> PARHM Demonstration	

PART B - MEDICAL AND OTHER HEALTH SERVICES	1
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TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)		90
91	Outlier reconciliation adjustment amount (see instructions)		91
92	The rate used to calculate the Time Value of Money		92
93	Time Value of Money (see instructions)		93
94	Total (sum of lines 90 and 93)		94

ANALYSIS OF PAYMENTS TO PROVIDERS
FOR SERVICES RENDERED

PROVIDER CCN:
11-0177
COMPONENT CCN:

PERIOD:
FROM: 04/01/2021
TO: 03/31/2022

WORKSHEET E-1,
Part I

Check Hospital Subprovider (Other) PARHM Demonstration
Applicable IPF SNF PARHM CAH Swing-Bed SNF
Boxes: IRF Swing-Bed SNF Chart Model
 Chart CAH Swing-Bed SNF

Description	Inpatient		Part B		
	Part A		Part B		
	mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1 Total interim payments paid to provider		40,834,102		11,857,564	1
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary 2 for services rendered in the cost reporting period. If none, write "NONE" or enter a zero					2
3 List separately each retroactive Program to Provider .01 3.01 lump sum adjustment amount based .02 3.02 on subsequent revision of the .03 3.03 interim rate for the cost reporting period. .04 3.04 Also show date of each payment. .05 3.05 If none, write "NONE" or enter a zero. (1)	Program to Provider	0.01			3.01
		0.02			3.02
		0.03			3.03
		0.04			3.04
		0.05			3.05
	Provider to Program	0.5			3.5
		0.51			3.51
		0.52			3.52
		0.53			3.53
	0.54			3.54	
Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98)	0.99				3.99
4 Total interim payments (sum of lines 1, 2, and 3.99) 4 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		40,834,102		11,857,564	4
5 List separately each tentative settlement Program to Provider .01 5.01 payment after desk review. Also show .02 5.02 date of each payment. .03 5.03 If none, write "NONE" or enter a zero. (1)	Program to Provider	0.01			5.01
		0.02			5.2
		0.03			5.03
	Provider to Program	0.5			5.5
		0.51			5.51
		0.52			5.52
	Subtotal (sum of lines 5.01- 5.49 minus sum of lines 5.50-5.98)	0.99			
6 Determined net settlement amount (balance due) based on cost report (1)	Program to Provider	0.01			6.01
	Provider to Program	0.02		40,025	6.02
7 Total Medicare program liability (see instructions)			42,238,692	11,817,539	7
8 Name of Contractor WISCONSIN PHYSICIAN SERVICES	Contractor Number 5901		NPR Date (Month/Day/Year)		8

1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

ANALYSIS OF PAYMENTS TO PROVIDERS
FOR SERVICES RENDERED

PROVIDER CCN:
11-0177
COMPONENT CCN:

PERIOD:
FROM: 04/01/2021
TO: 03/31/2022

WORKSHEET E-1,
Part I

Check Hospital Subprovider (Other) PARHM Demonstration
Applicable IPF SNF PARHM CAH Swing-Bed SNF
Boxes: IRF Swing-Bed SNF Chart Model
 Chart CAH Swing-Bed SNF

Description	Inpatient		Part B		
	Part A		Part B		
	mm/dd/yyyy 1	Amount 2	mm/dd/yyyy 3	Amount 4	
1 Total interim payments paid to provider		4,843,198		598	1
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary 2 for services rendered in the cost reporting period. If none, write "NONE" or enter a zero					2
3 List separately each retroactive Program to Provider .01 3.01 lump sum adjustment amount based .02 3.02 on subsequent revision of the .03 3.03 interim rate for the cost reporting period. .04 3.04 Also show date of each payment. .05 3.05 If none, write "NONE" or enter a zero. (1)	Program to Provider	0.01			3.01
		0.02			3.02
		0.03			3.03
		0.04			3.04
		0.05			3.05
	Provider to Program	0.5			3.5
		0.51			3.51
		0.52			3.52
		0.53			3.53
		0.54			3.54
Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98)	0.99				3.99
4 Total interim payments (sum of lines 1, 2, and 3.99) 4 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,843,198		598	4
5 List separately each tentative settlement Program to Provider .01 5.01 payment after desk review. Also show .02 5.02 date of each payment. .03 5.03 If none, write "NONE" or enter a zero. (1)	Program to Provider	0.01			5.01
		0.02			5.2
		0.03			5.03
	Provider to Program	0.5			5.5
		0.51			5.51
		0.52			5.52
	Subtotal (sum of lines 5.01- 5.49 minus sum of lines 5.50-5.98)	0.99			
6 Determined net settlement amount (balance due) based on cost report (1)	Program to Provider	0.01			6.01
	Provider to Program	0.02		61	6.02
7 Total Medicare program liability (see instructions)			5,322,726	537	7
8 Name of Contractor WISCONSIN PHYSICIAN SERVICES	Contractor Number 5901		NPR Date (Month/Day/Year)		8

1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

CALCULATION OF REIMBURSEMENT SETTLEMENT	PROVIDER CCN: 11-0177 COMPONENT CCN:	PERIOD: FROM: 04/01/2021 TO: 03/31/2022	WORKSHEET E-3, PART III
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Check Applicable Box:	<input type="checkbox"/> Hospital <input checked="" type="checkbox"/> Subprovider IRF
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PART III - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IRF PPS

1

1	Net Federal PPS payment (see instructions)	4,468,517	1
2	Medicare SSI ratio (IRF PPS only) (see instructions)	0	2
3	Inpatient Rehabilitation LIP payments (see instructions)	744,008	3
4	Outlier payments	164,796	4
5	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		5
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2)		5.01
6	New teaching program adjustment (see instructions)		6
7	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		7
8	Current year unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		8
9	Intern and resident count for IRF PPS medical education adjustment (see instructions)		9
10	Average daily census (see instructions)	20	10
11	Teaching Adjustment Factor (see instructions)		11
12	Teaching Adjustment (see instructions)		12
13	Total PPS Payment (see instructions)	5,377,321	13
14	Nursing and allied health managed care payments (see instructions)		14
15	Organ acquisition DO NOT USE THIS LINE		15
16	Cost of physicians' services in a teaching hospital (see instructions)		16
17	Subtotal (see instructions)	5,377,321	17
18	Primary payer payments		18
19	Subtotal (line 17 less line 18)	5,377,321	19
20	Deductibles	31,376	20
21	Subtotal (line 19 minus line 20)	5,345,945	21
22	Coinsurance	29,010	22
23	Subtotal (line 21 minus line 22)	5,316,935	23
24	Allowable bad debts (exclude bad debts for professional services) (see instructions)	8,909	24
25	Adjusted reimbursable bad debts (see instructions)	5,791	25
26	Allowable bad debts for dual eligible beneficiaries (see instructions)	1,408	26
27	Subtotal (sum of lines 23 and 25)	5,322,726	27
28	Direct graduate medical education payments (from Wkst. E-4, line 49) (see instructions)		28
29	Other pass through costs (see instructions)		29
30	Outlier payments reconciliation		30
31	Other adjustments (specify) (see instructions)		31
31.5	Pioneer ACO demonstration payment adjustment (see instructions)		31.5
31.99	Demonstration payment adjustment amount before sequestration		31.99
32	Total amount payable to the provider (see instructions)	5,322,726	32
32.01	Sequestration adjustment (see instructions)		32.01
32.02	Demonstration payment adjustment amount after sequestration		32.02
33	Interim payments	4,843,198	33
34	Tentative settlement (for contractor use only)		34
35	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	479,528	35
36	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		36

TO BE COMPLETED BY CONTRACTOR

50	Original outlier amount from Wkst. E-3, Pt. III, line 4 (see instructions)	164,796	50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the Time Value of Money (see instructions)		52
53	Time Value of Money (see instructions)		53

CALCULATION OF REIMBURSEMENT SETTLEMENT		PROVIDER CCN: 11-0177	PERIOD: FROM: 04/01/2021 TO: 03/31/2022	WORKSHEET E-3, PART VII
Check Applicable Boxes:	<input type="checkbox"/> Title V <input checked="" type="checkbox"/> Title XIX	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Subprovider <input type="checkbox"/> SNF	<input type="checkbox"/> NF <input type="checkbox"/> ICF/IID	<input type="checkbox"/> PPS <input type="checkbox"/> TEFRA <input type="checkbox"/> Other

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES

	1	2	
	Inpatient Title V or Title XIX	Outpatient Title V or Title XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1 Inpatient hospital/SNF/NF services	11,772,538		1
2 Medical and other services		1,896,056	2
3 Organ acquisition (certified transplant programs only)			3
4 Subtotal (sum of lines 1, 2 and 3)			4
5 Inpatient primary payer payments	91,890		5
6 Outpatient primary payer payments			6
7 Subtotal (line 4 less sum of lines 5 and 6)	11,680,648	1,896,056	7
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable Charges			
8 Routine service charges	39,908,726		8
9 Ancillary service charges	96,229,582	22,090,100	9
10 Organ acquisition charges, net of revenue			10
11 Incentive from target amount computation			11
12 Total reasonable charges (sum of lines 8 through 11)	136,138,308	22,090,100	12
CUSTOMARY CHARGES			
13 Amount actually collected from patients liable for payment for services on a charge basis			13
14 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)			14
15 Ratio of line 13 to line 14 (not to exceed 1.000000)			15
16 Total customary charges (see instructions)	136,138,308	22,090,100	16
17 Excess of customary charges over reasonable cost (complete only if line 16 17 exceeds line 4) (see instructions)	124,365,770	20,194,044	17
18 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19 Interns and residents (see instructions)			19
20 Cost of physicians' service in a teaching hospital (see instructions)			20
21 Cost of covered services (enter the lesser of line 4 or line 16)	11,772,538	1,896,056	21
PROSPECTIVE PAYMENT AMOUNT			
22 Other than outlier payments			22
23 Outlier payments			23
24 Program capital payments			24
25 Capital exception payments (see instructions)			25
26 Routine and ancillary service other pass through costs			26
27 Subtotal (sum of lines 22 through 26)			27
28 Customary charges (title V or XIX PPS covered services only)			28
29 Titles V or XIX (sum of lines 21 and 27)	11,772,538	1,896,056	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30 Excess of reasonable cost (from line 18)			30
31 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	11,680,648	1,896,056	31
32 Deductibles			32
33 Coinsurance	2,331	10,003	33
34 Allowable bad debts (see instructions)			34
35 Utilization review			35
36 Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	11,678,317	1,886,053	36
37 Other adjustments (specify) (see instructions)	(1,206,641)	(80,203)	37
38 Subtotal (line 36 ± line 37)	10,471,676	1,805,850	38
39 Direct graduate medical education payments (from Wkst. E-4)			39
40 Total amount payable to the provider (sum of lines 38 and 39)	10,471,676	1,805,850	40
41 Interim payments	10,471,676	1,378,926	41
42 Balance due provider/program (line 40 minus line 41)		426,924	42
43 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		PROVIDER CCN: 11-0177	PERIOD: FROM: 04/01/2021 TO: 03/31/2022	WORKSHEET E-4
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Check Applicable Boxes:	<input type="checkbox"/> Title V <input checked="" type="checkbox"/> Title XVIII <input type="checkbox"/> Title XIX	<input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Subprovider <input type="checkbox"/> SNF	<input type="checkbox"/> CAH-Based IPF <input type="checkbox"/> CAH-Based IRF
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COMPUTATION OF TOTAL DIRECT GME AMOUNT				1
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			1.01
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			2.26
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions 3.01 for cost reporting periods straddling 7/1/2011)			3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			3.02
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			4.21
5	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus 5 line 4, plus lines 4.01 through 4.27)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			2
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for 8 the current year	0	1	2
9	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.			9
10	Weighted dental and podiatric resident FTE count for the current year			10
10.01	Unweighted dental and podiatric resident FTE count for the current year			10
11	Total weighted FTE count			11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)			12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instr.)			13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)			14
15	Adjustment for residents in initial years of new programs			15
15.01	Unweighted adjustment for residents in initial years of new programs			15
16	Adjustment for residents displaced by program or hospital closure			16
16.01	Unweighted adjustment for residents displaced by program or hospital closure			16
17	Adjusted rolling average FTE count			17
18	Per resident amount			18
18.01	Per resident amount under §131 of the CAA 2021			18
19	Approved amount for resident costs			19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			20
21	Direct GME FTE unweighted resident count over cap (see instructions)	2		21
22	Allowable additional direct GME FTE resident count (see instructions)			22
23	Enter the locality adjustment national average per resident amount (see instructions)			23
24	Multiply line 22 time line 23			24
25	Total direct GME amount (sum of lines 19 and 24)			25
COMPUTATION OF PROGRAM PATIENT LOAD				Total
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or After 1/1
		1	2	2.01
26	Inpatient Days (see instructions)	20,368	13,467	13,177
27	Total Inpatient Days (see instructions)	96,174	96,174	96,174
28	Ratio of inpatient days to total inpatient days	0	0	0
29	Program direct GME amount			29
29.01	Percent reduction for MA DGME		4	4
30	Reduction for direct GME payments for Medicare Advantage			30
31	Net Program direct GME amount			31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			12,340,770
34	Ratio of direct medical education costs to total charges (line 32 + line 33)			34
35	Medicare outpatient ESRD charges (see instructions)			35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			36

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		PROVIDER CCN: 11-0177	PERIOD: FROM: 04/01/2021 TO: 03/31/2022	WORKSHEET E-4
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Check	<input type="checkbox"/> Title V	<input checked="" type="checkbox"/> Hospital	<input type="checkbox"/> CAH-Based IPF
Applicable	<input checked="" type="checkbox"/> Title XVIII	<input type="checkbox"/> Subprovider	<input type="checkbox"/> CAH-Based IRF
Boxes:	<input type="checkbox"/> Title XIX	<input type="checkbox"/> SNF	

APPORTIONMENT OF MEDICARE REASONABLE COST OF GME			1
Part A Reasonable Cost			
37	Reasonable cost (see instructions)	47,019,837	37
38	Organ acquisition costs Wkst. D-4, Pt. III, col. 1, line 69)		38
39	Cost of physicians' services in a teaching hospital (see instructions)		39
40	Primary payer payments (see instructions)	59,227	40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	46,960,610	41
Part B Reasonable Cost			
42	Reasonable cost (see instructions)	16,622,664	42
43	Primary payer payments (see instructions)	3,030	43
44	Total Part B reasonable cost (line 42 minus line 43)	16,619,634	44
45	Total reasonable cost (sum of lines 41 and 44)	63,580,244	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.738604	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.261396	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B			
48	Total program GME payment (line 31)		48
49	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		49
50	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions) 50		50