

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all inter-
payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 2/1/2021 2:11 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/1/2021	Time: 2:11 pm
	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	6. Date Received:	10. NPR Date:
	(1) As Submitted	7. Contractor No.	11. Contractor's Vendor Code: 4
	(2) Settled without Audit	8. ☐ Initial Report for this Provider CCN	12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.
	(3) Settled with Audit	9. ☐ Final Report for this Provider CCN	
	(4) Reopened		
	(5) Amended		

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 THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE 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 JERSEY COMMUNITY HOSPITAL DIST (14-0059) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 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) BETH KING

Officer or Administrator of Provider(s)

CEO

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			
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-119,619	18,284	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	90	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		445,259		0	10.00
200.00	Total	0	-119,529	463,543	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 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 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.

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 2:11 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street:400 MAPLE SUMMIT ROAD		PO Box:						1.00	
2.00	City: JERSEYVILLE		State: IL		Zip Code:62052		County: JERSEY		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		JERSEY COMMUNITY HOSPITAL DIST	140059	41180	1	07/11/1996	N	P	O
4.00	Subprovider - IPF									
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF		JERSEY COMMUNITY HOSPITAL	14U059	41180		08/27/1993	N	P	N
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC		JCH MEDICAL GROUP JERSEYVILLE	148538	41180		01/01/2015	N	O	N
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2019	06/30/2020		20.00	
21.00	Type of Control (see instructions)					11			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	
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.					1	N		23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 2:11 pm				
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days							
	1.00	2.00	3.00	4.00	5.00	6.00							
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						0	0	0	0	0	0	25.00
							Urban/Rural Status	Date of Geographic Reclassification					
							1.00	2.00					
26.00	Enter your standard geographic classification (not wage) status at the beginning of the 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 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.						1		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.						07/01/2019	06/30/2020	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)						Y	Y	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	45.00			
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.							N	N	46.00			
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.						N	N	N	47.00			
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.						N	N	N	48.00			
Teaching Hospitals													
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.									56.00			
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.									57.00			
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.									58.00			
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.						N			59.00			
							NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code				
							1.00	2.00	3.00				
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.						N			60.00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

	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 N 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)			0.00	0.00	61.00			
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01			
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02			
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03			
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04			
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05			
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06			
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count				
		1.00	2.00	3.00	4.00				
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10			
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20			
					1.00				
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00		
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01		
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" N for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63.00		
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))					
		1.00	2.00	3.00					
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

	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
<u>Inpatient Psychiatric Facility PPS</u>							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00	
<u>Inpatient Rehabilitation Facility PPS</u>							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00	

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 2:11 pm	
			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.			N	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.			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	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	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	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			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	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			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	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	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	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	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	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	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	98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?			N	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00
			Physical	Occupational	
			1.00	2.00	
			Speech	Respiratory	
			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.				109.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 2:11 pm	
			1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N			110.00
			1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N			111.00
			1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model 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			115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
			Premiums	Losses	Insurance
			1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	338,876	0		118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §312N 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			120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
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

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020		
				Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 2:11 pm		
		1.00		2.00		
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)				140.00	
1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name:		Contractor's Name:		141.00	
142.00	Street:		PO Box:		142.00	
143.00	City:		State:		143.00	
				Zip Code:		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00
		1.00		2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				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		
		1.00		2.00		
		Title V		Title XIX		
		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	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
				1.00		
Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00
		Name		County		
		0		1.00		
		State		Zip Code		
		2.00		3.00		
		CBSA		FTE/Campus		
		4.00		5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00	166.00
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)				N	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)				9.99	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 2/1/2021 2:11 pm
			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

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020	
		Worksheet S-2 Part II Date/Time Prepared: 2/1/2021 2:11 pm			
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
		Y/N	Type	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.	Y			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the 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 reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.				13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N		14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N		15.00
		Part A		Part B	
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/09/2020	Y	11/09/2020
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020	
		Worksheet S-2 Part II Date/Time Prepared: 2/1/2021 2:11 pm			
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N		20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N			27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	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.	Y			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.	Y			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.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	NELSON		41.00
42.00	Enter the employer/company name of the cost report preparer	RSM US LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	612-655-4706	JILL.NELSON@RSMUS.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
2/1/2021 2:11 pm

		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.	MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

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	42	15,372	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)		42	15,372	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,464	0.00	0	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)		46	16,836	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 RHC (CONSOLIDATED)	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		46				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents	
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll
		6.00	7.00	8.00	9.00	10.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,120	24	1,861		1.00
2.00	HMO and other (see instructions)	294	97			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	72	0	82		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,192	24	1,943		7.00
8.00	INTENSIVE CARE UNIT	187	20	283		8.00
9.00	CORONARY CARE UNIT					9.00
10.00	BURN INTENSIVE CARE UNIT					10.00
11.00	SURGICAL INTENSIVE CARE UNIT					11.00
12.00	OTHER SPECIAL CARE (SPECIFY)					12.00
13.00	NURSERY					13.00
14.00	Total (see instructions)	1,379	44	2,226	0.00	249.77
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	RHC (CONSOLIDATED)	18,653	13,713	65,334	0.00	89.07
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00
27.00	Total (sum of lines 14-26)				0.00	338.84
28.00	Observation Bed Days		4	893		28.00
29.00	Ambulance Trips	1,306				29.00
30.00	Employee discount days (see instruction)			0		30.00
31.00	Employee discount days - IRF			0		31.00
32.00	Labor & delivery days (see instructions)	0	0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0		32.01
33.00	LTCH non-covered days	0				33.00
33.01	LTCH site neutral days and discharges	0				33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

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	414	12	644	1.00
2.00 HMO and other (see instructions)			79	35		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	414	12	644	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 RHC (CONSOLIDATED)	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
2/1/2021 2:11 pm

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	21,163,770	0	21,163,770	704,796.00	30.03
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		2,920,788	0	2,920,788	28,716.00	101.71
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		3,369,049	0	3,369,049	156,556.00	21.52
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		1,452,533	230,955	1,683,488	90,349.00	18.63
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,178,910	0	1,178,910	20,496.00	57.52
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		112,062	0	112,062	1,683.00	66.58
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,636,395	0	3,636,395		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		637,835	0	637,835		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		338,750	0	338,750		
24.00	Wage-related costs (RHC/FQHC)		1,175,351	0	1,175,351		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
2/1/2021 2:11 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	193,300	0	193,300	6,618.00	29.21	26.00
27.00	Administrative & General	5.00	2,451,891	0	2,451,891	91,219.00	26.88	27.00
28.00	Administrative & General under contract (see inst.)		266,270	0	266,270	5,325.00	50.00	28.00
29.00	Maintenance & Repairs	6.00	262,126	0	262,126	8,596.00	30.49	29.00
30.00	Operation of Plant	7.00	128,977	0	128,977	3,929.00	32.83	30.00
31.00	Laundry & Linen Service	8.00	33,562	0	33,562	2,145.00	15.65	31.00
32.00	Housekeeping	9.00	235,193	0	235,193	18,526.00	12.70	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	321,566	0	321,566	22,359.00	14.38	34.00
35.00	Dietary under contract (see instructions)		29,700	0	29,700	743.00	39.97	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	454,787	0	454,787	11,640.00	39.07	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	314,539	0	314,539	14,418.00	21.82	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
2/1/2021 2:11 pm

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	15,169,903	0	15,169,903	525,592.00	28.86	1.00
2.00	Excluded area salaries (see instructions)	1,452,533	230,955	1,683,488	90,349.00	18.63	2.00
3.00	Subtotal salaries (line 1 minus line 2)	13,717,370	-230,955	13,486,415	435,243.00	30.99	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,290,972	0	1,290,972	22,179.00	58.21	4.00
5.00	Subtotal wage-related costs (see inst.)	3,636,395	0	3,636,395	0.00	26.96	5.00
6.00	Total (sum of lines 3 thru 5)	18,644,737	-230,955	18,413,782	457,422.00	40.26	6.00
7.00	Total overhead cost (see instructions)	4,691,911	0	4,691,911	185,518.00	25.29	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
2/1/2021 2:11 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	631,557	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3,542,949	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	31,603	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	7,387	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	158,375	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	1,400,650	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	15,809	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,788,330	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,178,910	5,788,330	1.00
2.00	Hospital	1,178,910	4,274,230	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	1,514,100	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-0059 Component CCN:14-8538		Period: From 07/01/2019 To 06/30/2020 Worksheet S-8 Date/Time Prepared: 2/1/2021 2:11 pm	
		RHC I		Cost	
		1.00			
1.00	Clinic Address and Identification				
	Street		390 MAPLE SUMMIT ROAD 1.00		
			City	State	ZIP Code
			1.00	2.00	3.00
2.00	City, State, ZIP Code, County		JERSEYVILLE IL 62052 2.00		
				1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0 3.00
		Grant Award		Date	
		1.00		2.00	
		Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)		4.00		
5.00	Migrant Health Center (Section 329(d), PHS Act)		5.00		
6.00	Health Services for the Homeless (Section 340(d), PHS Act)		6.00		
7.00	Appalachian Regional Commission		7.00		
8.00	Look-Alikes		8.00		
9.00	OTHER (SPECIFY)		9.00		
				1.00 2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		yes or N 0		10.00
		Sunday		Monday	
		from to		from to	
		1.00 2.00		3.00 4.00	
				Tuesday	
				from	
				1.00 2.00	
11.00	Facility hours of operations (1)				
	CLINIC		08:00 17:00 08:00 11.00		
				1.00 2.00	
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Y		6		13.00
		Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			
		Provider name		CCN number	
		1.00		2.00	
14.00	RHC/FQHC name, CCN number		JCH MEDICAL GROUP CARROLLTON 148537 14.00		
14.01			JCH MEDICAL GROUP HARDIN 148539 14.01		
14.02			JCH MEDICAL GROUP ROODHOUSE 148540 14.02		
14.03			JCH MEDICAL GROUP JERSEYVILLE 148550 14.03		
14.04			II JCH MEDICAL GROUP JERSEYVILLE 148604 14.04		
14.05			III JCH MEDICAL GROUP JERSEYVILLE 148610 14.05		
				IV	
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		Total Visits 15.00		

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN:14-0059 Component CCN:14-8538		Period: From 07/01/2019 To 06/30/2020	Worksheet S-8 Date/Time Prepared: 2/1/2021 2:11 pm
				RHC I	Cost
		County			
		4.00			
2.00	City, State, ZIP Code, County	JERSEY		2.00	
		Tuesday	Wednesday	Thursday	
		to	from to	from to	
		6.00	7.00 8.00	9.00 10.00	
Facility hours of operations (1)					
11.00	CLINIC	17:00	08:00	17:00	08:00 17:00
		Friday		Saturday	
		from to	from to		
		11.00 12.00	13.00 14.00		
Facility hours of operations (1)					
11.00	CLINIC	08:00	17:00		11.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet S-10 Date/Time Prepared: 2/1/2021 2:11 pm	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.365792		1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	1,251,359		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N		4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	1,528,519		5.00	
6.00	Medicaid charges	10,124,261		6.00	
7.00	Medicaid cost (line 1 times line 6)	3,703,374		7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	923,496		8.00	
Children's Health Insurance Program (CHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone CHIP	0		9.00	
10.00	Stand-alone CHIP charges	0		10.00	
11.00	Stand-alone CHIP cost (line 1 times line 10)	0		11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0		12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0		13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0		14.00	
15.00	State or local indigent care program cost (line 1 times line 14)	0		15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0		16.00	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care	0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations	0		18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12, 13, 14, 15, 16, 17, 18, and 19)	1,923,496		19.00	
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	39,930	77,670	117,600	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	14,606	77,670	92,276	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	14,606	77,670	92,276	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N		24.00	
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0		25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)	2,547,666		26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	283,838		27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	436,674		27.01	
28.00	Non-Medicare bad debt expense (see instructions)	2,110,992		28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	925,020		29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,017,296		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,940,792		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification 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		995,585	995,585	307,432	1,303,017	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		877,677	877,677	147,532	1,025,209	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	193,300	4,426,581	4,619,881	158,375	4,778,256	4.00
5.01	00590	BUSINESS OFFICE - BILLING	281,628	555,297	836,925	-1,349	835,576	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	2,170,263	4,738,686	6,908,949	-165,984	6,742,965	5.02
6.00	00600	MAINTENANCE & REPAIRS	262,126	319,881	582,007	0	582,007	6.00
7.00	00700	OPERATION OF PLANT	128,977	920,627	1,049,604	0	1,049,604	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	33,562	94,062	127,624	0	127,624	8.00
9.00	00900	HOUSEKEEPING	235,193	113,811	349,004	0	349,004	9.00
10.00	01000	DIETARY	321,566	276,528	598,094	0	598,094	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	454,787	59,653	514,440	0	514,440	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,883	1,883	0	1,883	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	314,539	290,680	605,219	-40,041	565,178	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	681,004	681,004	0	681,004	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,173,424	584,905	1,758,329	-6,063	1,752,266	30.00
31.00	03100	INTENSIVE CARE UNIT	507,152	50,808	557,960	0	557,960	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	371,037	530,307	901,344	-117,612	783,732	50.00
51.00	05100	RECOVERY ROOM	67,570	7,434	75,004	0	75,004	51.00
53.00	05300	ANESTHESIOLOGY	3,571	21,272	24,843	0	24,843	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	994,605	1,109,077	2,103,682	-287,160	1,816,522	54.00
60.00	06000	LABORATORY	962,128	880,643	1,842,771	0	1,842,771	60.00
66.00	06600	PHYSICAL THERAPY	0	1,014,691	1,014,691	0	1,014,691	66.00
69.00	06900	ELECTROCARDIOLOGY	313,898	68,553	382,451	-21,775	360,676	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	461,426	461,426	74,823	536,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,083,658	1,083,658	0	1,083,658	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	515,486	1,603,814	2,119,300	0	2,119,300	73.00
75.00	07500	ASC (NON-DISTINCT PART)	592,058	176,054	768,112	0	768,112	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	6,289,837	1,722,222	8,012,059	-368,714	7,643,345	88.00
90.00	09000	CLINIC	1,522,940	1,160,486	2,683,426	0	2,683,426	90.00
91.00	09100	EMERGENCY	2,001,590	1,175,901	3,177,491	-343	3,177,148	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	819,438	150,502	969,940	-43	969,897	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	27,960	27,960	0	27,960	97.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,530,675	26,181,668	46,712,343	-320,922	46,391,421	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	369,208	255,187	624,395	320,922	945,317	192.00
192.01	19201	WELLNESS CENTER	263,887	167,434	431,321	0	431,321	192.01
192.03	19203	COMMUNITY RELATIONS	0	228,655	228,655	0	228,655	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	21,163,770	26,832,944	47,996,714	0	47,996,714	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
2/1/2021 2:11 pm

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	-118,702	1,184,315	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,025,209	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-786,257	3,991,999	4.00
5.01	00590	BUSINESS OFFICE - BILLING	0	835,576	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	-3,056,854	3,686,111	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	582,007	6.00
7.00	00700	OPERATION OF PLANT	0	1,049,604	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	127,624	8.00
9.00	00900	HOUSEKEEPING	0	349,004	9.00
10.00	01000	DIETARY	-165,855	432,239	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	514,440	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,883	14.00
15.00	01500	PHARMACY	-114	-114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,683	556,495	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-681,004	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-400,826	1,351,440	30.00
31.00	03100	INTENSIVE CARE UNIT	0	557,960	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	783,732	50.00
51.00	05100	RECOVERY ROOM	0	75,004	51.00
53.00	05300	ANESTHESIOLOGY	0	24,843	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-161,516	1,655,006	54.00
60.00	06000	LABORATORY	-4,400	1,838,371	60.00
66.00	06600	PHYSICAL THERAPY	0	1,014,691	66.00
69.00	06900	ELECTROCARDIOLOGY	0	360,676	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	536,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,083,658	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,119,300	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	768,112	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-202,510	7,440,835	88.00
90.00	09000	CLINIC	-991,099	1,692,327	90.00
91.00	09100	EMERGENCY	-1,583,501	1,593,647	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-16,930	952,967	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	27,960	97.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,178,251	38,213,170	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	945,317	192.00
192.01	19201	WELLNESS CENTER	-173	431,148	192.01
192.03	19203	COMMUNITY RELATIONS	0	228,655	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,178,424	39,818,290	200.00

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	A - WORKERS COMPENSATION					1.00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	158,375		
	TOTALS		0	158,375		
1.00	B - PROPERTY INSURANCE					1.00
	OTHER CAP REL COSTS	3.00	0	4,083		
	TOTALS		0	4,083		
1.00	C - RENTAL EXPENSE					1.00
	CAP REL COSTS-BLDG & FIXT	1.00	0	304,735		
	CAP REL COSTS-MVBLE EQUIP	2.00	0	146,146		
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
	TOTALS		0	450,881		
1.00	E - MEDICAL GROUP ADMIN					1.00
	PHYSICIANS' PRIVATE OFFICES	192.00	138,979	95,044		
	TOTALS		138,979	95,044		
1.00	F - WALK-IN CLINIC					1.00
	PHYSICIANS' PRIVATE OFFICES	192.00	91,976	42,715		
	TOTALS		91,976	42,715		
1.00	I - OR SUPPLIES					1.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	74,823		
	TOTALS		0	74,823		
500.00	Grand Total: Increases		230,955	825,921	500.00	

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
1.00	A - WORKERS COMPENSATION						1.00
	ADMINISTRATIVE AND GENERAL	5.02	0	158,375	0		
	TOTALS		0	158,375			
1.00	B - PROPERTY INSURANCE						1.00
	ADMINISTRATIVE AND GENERAL	5.02	0	4,083	12		
	TOTALS		0	4,083			
1.00	C - RENTAL EXPENSE						1.00
	BUSINESS OFFICE - BILLING	5.01	0	1,349	10		
	ADMINISTRATIVE AND GENERAL	5.02	0	3,526	10		
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	40,041	0	3.00	
4.00	ADULTS & PEDIATRICS	30.00	0	6,063	0	4.00	
5.00	OPERATING ROOM	50.00	0	42,789	0	5.00	
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	287,160	0	6.00	
7.00	ELECTROCARDIOLOGY	69.00	0	21,775	0	7.00	
8.00	EMERGENCY	91.00	0	343	0	8.00	
9.00	AMBULANCE SERVICES	95.00	0	43	0	9.00	
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	47,792	0	10.00	
	TOTALS		0	450,881			
1.00	E - MEDICAL GROUP ADMIN						1.00
	RURAL HEALTH CLINIC	88.00	138,979	95,044	0		
	TOTALS		138,979	95,044			
1.00	F - WALK-IN CLINIC						1.00
	RURAL HEALTH CLINIC	88.00	91,976	42,715	0		
	TOTALS		91,976	42,715			
1.00	I - OR SUPPLIES						1.00
	OPERATING ROOM	50.00	0	74,823	0		
	TOTALS		0	74,823			
500.00	Grand Total: Decreases		230,955	825,921		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

		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	55,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,108,028	482,502	0	482,502	0	3.00
4.00	Building Improvements	6,828,366	555,644	0	555,644	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,182,053	713,224	0	713,224	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,173,447	1,751,370	0	1,751,370	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,173,447	1,751,370	0	1,751,370	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	55,000	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	19,590,530	0				3.00
4.00	Building Improvements	7,384,010	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	13,895,277	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	40,924,817	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	40,924,817	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
2/1/2021 2:11 pm

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	800,410	0	195,175	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	877,677	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,678,087	0	195,175	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	995,585				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	877,677				2.00
3.00	Total (sum of lines 1-2)	0	1,873,262				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
2/1/2021 2:11 pm

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	27,029,539	0	27,029,539	0.660468	2,697	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	13,895,277	0	13,895,277	0.339532	1,386	2.00
3.00	Total (sum of lines 1-2)	40,924,816	0	40,924,816	1.000000	4,083	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	2,697	799,935	304,735	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	1,386	877,677	146,146	2.00
3.00	Total (sum of lines 1-2)	0	0	4,083	1,677,612	450,881	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	76,948	2,697	0	0	1,184,315	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,386	0	0	1,025,209	2.00
3.00	Total (sum of lines 1-2)	76,948	4,083	0	0	2,209,524	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-118,227	CAP REL COSTS-BLDG & FIXT	1.00		11 1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		0 2.00
3.00	Investment income - other (chapter 2)		0		0.00		0 3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	0	ADMINISTRATIVE AND GENERAL	5.02		0 4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00		0 5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00		0 6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,147	ADMINISTRATIVE AND GENERAL	5.02		0 7.00
8.00	Television and radio service (chapter 21)	A	-475	CAP REL COSTS-BLDG & FIXT	1.00		9 8.00
9.00	Parking lot (chapter 21)		0		0.00		0 9.00
10.00	Provider-based physician adjustment	A-8-2	-3,140,542				0 10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00		0 11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0				0 12.00
13.00	Laundry and linen service		0		0.00		0 13.00
14.00	Cafeteria-employees and guests	B	-164,520	DIETARY	10.00		0 14.00
15.00	Rental of quarters to employees and others	B	-64,706	ADMINISTRATIVE AND GENERAL	5.02		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	B	-114	PHARMACY	15.00		0 17.00
18.00	Sale of medical records and abstracts	B	-8,683	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	B	-1,335	DIETARY	10.00		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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00		0 26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00		0 27.00
28.00	Non-physician Anesthetist	A	-681,004	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00		0 29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** 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 REV	B	-210,947	ADMINISTRATIVE AND GENERAL	5.02		0 33.00

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8
Date/Time Prepared:
2/1/2021 2:11 pm

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
Cost Center Description	Basis/Code (2)	Amount	Cost Center		Line #	Wkst. A-7 Ref.	
			1.00	2.00			
33.01	PHYSICIAN RECRUITMENT	A	-54,598	ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.02	NON PATIENT LAB REV	B	-800	LABORATORY	60.00	0	33.02
33.03	LIFE LINE REVENUE	B	-27,099	ADMINISTRATIVE AND GENERAL	5.02	0	33.03
33.04	BAD DEBTS	A	-2,547,666	ADMINISTRATIVE AND GENERAL	5.02	0	33.04
33.05	SELF INSURANCE CLAIMS	A	-661,325	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	ADVERTISING	A	-59,005	ADMINISTRATIVE AND GENERAL	5.02	0	33.06
33.07	MARKETING SALARIES	A	-30,171	ADMINISTRATIVE AND GENERAL	5.02	0	33.07
33.08	MARKETING BENEFITS	A	-8,089	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	LOBBYING EXPENSES	A	-13,697	ADMINISTRATIVE AND GENERAL	5.02	0	33.09
33.10	ADVERTISING	A	-173	WELLNESS CENTER	192.01	0	33.10
33.11	MISCELLANEOUS EXPENSE	A	0		0.00	0	33.11
33.12	FOUNDATION SALARIES	A	-46,818	ADMINISTRATIVE AND GENERAL	5.02	0	33.12
33.13	FOUNDATION BENEFITS	A	-12,552	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	RECYCLING REVENUE - MISC	B	0	ADMINISTRATIVE AND GENERAL	5.02	0	33.14
33.15	NON-ALLOWABLE CHAMBER DUES	A	0	ADMINISTRATIVE AND GENERAL	5.02	0	33.15
33.16	GIFT SHOP REVENUE	B	0	ADMINISTRATIVE AND GENERAL	5.02	0	33.16
33.17	NP - HOSPITALIST	A	-202,510	RURAL HEALTH CLINIC	88.00	0	33.17
33.18	HOSPITALIST BENEFITS	A	-44,206	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	PATIENT TELEVISION EXPENSE	A	0	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	EMS TRAINING REVENUE	B	-16,930	AMBULANCE SERVICES	95.00	0	33.20
33.21	ED PHYSICIAN BENEFITS	A	-60,085	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.21
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,178,424				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
2/1/2021 2:11 pm

	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	91.00	EMERGENCY	779,356	779,356	0	0	0	1.00
2.00	91.00	EMERGENCY	804,145	804,145	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	400,826	400,826	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	161,516	161,516	0	0	0	4.00
5.00	60.00	LABORATORY	3,600	3,600	0	0	0	5.00
6.00	90.00	CLINIC	991,099	991,099	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			3,140,542	3,140,542	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	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			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	779,356		1.00
2.00	91.00	EMERGENCY	0	0	0	804,145		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	400,826		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	161,516		4.00
5.00	60.00	LABORATORY	0	0	0	3,600		5.00
6.00	90.00	CLINIC	0	0	0	991,099		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			0	0	0	3,140,542		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE - BILLING	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,184,315	1,184,315			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,025,209	1,025,209			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,991,999	1,999	0	3,993,998	4.00
5.01	00590	BUSINESS OFFICE - BILLING	835,576	6,905	573	53,638	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	3,686,111	148,805	382,645	413,344	5.02
6.00	00600	MAINTENANCE & REPAIRS	582,007	43,093	0	49,924	6.00
7.00	00700	OPERATION OF PLANT	1,049,604	0	0	24,565	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	127,624	4,225	1,945	6,392	8.00
9.00	00900	HOUSEKEEPING	349,004	2,650	0	44,794	9.00
10.00	01000	DIETARY	432,239	25,082	1,704	61,245	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	514,440	1,999	0	86,618	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,883	4,838	0	0	14.00
15.00	01500	PHARMACY	-114	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	556,495	10,523	51,455	59,906	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,351,440	42,987	20,389	223,488	30.00
31.00	03100	INTENSIVE CARE UNIT	557,960	15,990	2,477	96,591	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	783,732	31,230	103,934	70,667	50.00
51.00	05100	RECOVERY ROOM	75,004	2,960	0	12,869	51.00
53.00	05300	ANESTHESIOLOGY	24,843	1,181	0	680	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,655,006	48,862	180,372	189,430	54.00
60.00	06000	LABORATORY	1,838,371	22,485	33,059	183,245	60.00
66.00	06600	PHYSICAL THERAPY	1,014,691	23,863	1,578	0	66.00
69.00	06900	ELECTROCARDIOLOGY	360,676	22,357	30,701	59,784	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	536,249	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,083,658	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,119,300	8,366	32,471	98,178	73.00
75.00	07500	ASC (NON-DISTINCT PART)	768,112	26,793	10,904	112,762	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	7,440,835	262,148	28,596	1,153,969	88.00
90.00	09000	CLINIC	1,692,327	42,048	58,706	290,056	90.00
91.00	09100	EMERGENCY	1,593,647	50,036	5,459	381,219	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	952,967	36,605	53,954	156,069	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	27,960	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,213,170	888,030	1,000,922	3,829,433	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,869	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	945,317	98,694	6,848	114,306	192.00
192.01	19201	WELLNESS CENTER	431,148	193,041	17,439	50,259	192.01
192.03	19203	COMMUNITY RELATIONS	228,655	681	0	0	192.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	39,818,290	1,184,315	1,025,209	3,993,998	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Subtotal	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5A.01	5.02	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00500	BUSINESS OFFICE - BILLING					5.01
5.02	00501	ADMINISTRATIVE AND GENERAL	4,630,905	4,630,905			5.02
6.00	00600	MAINTENANCE & REPAIRS	675,024	88,838	763,862		6.00
7.00	00700	OPERATION OF PLANT	1,074,169	141,368	0	1,215,537	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	140,186	18,449	3,281	5,221	167,137
9.00	00900	HOUSEKEEPING	396,448	52,175	2,058	3,275	10,844
10.00	01000	DIETARY	520,270	68,471	19,481	30,999	0
11.00	01100	CAFETERIA	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	603,057	79,367	1,552	2,470	0
14.00	01400	CENTRAL SERVICES & SUPPLY	6,721	885	3,757	5,979	398
15.00	01500	PHARMACY	-114	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	678,379	89,279	8,173	13,006	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,663,414	218,917	33,387	53,129	53,683
31.00	03100	INTENSIVE CARE UNIT	677,326	89,141	12,419	19,762	4,614
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,029,094	135,436	24,255	38,597	10,001
51.00	05100	RECOVERY ROOM	92,888	12,225	2,299	3,659	0
53.00	05300	ANESTHESIOLOGY	47,616	6,267	917	1,460	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,310,828	304,121	37,950	60,389	15,341
60.00	06000	LABORATORY	2,226,210	292,985	17,464	27,790	0
66.00	06600	PHYSICAL THERAPY	1,095,975	144,238	18,534	29,493	0
69.00	06900	ELECTROCARDIOLOGY	503,361	66,246	17,364	27,631	913
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	548,599	72,199	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,093,972	143,974	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,306,966	303,613	6,497	10,339	0
75.00	07500	ASC (NON-DISTINCT PART)	939,383	123,629	20,809	33,114	13,046
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,975,757	1,181,257	203,601	323,993	422
90.00	09000	CLINIC	2,126,425	279,852	32,658	51,968	0
91.00	09100	EMERGENCY	2,118,684	278,834	38,861	61,840	34,032
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				0
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,218,524	160,366	28,430	45,241	0
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	27,966	3,681	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	37,728,033	4,355,813	533,747	849,355	143,294
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,869	509	3,005	4,781	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,165,165	153,344	76,652	121,977	3,560
192.01	19201	WELLNESS CENTER	691,887	91,057	149,929	238,582	20,283
192.03	19203	COMMUNITY RELATIONS	229,336	30,182	529	842	0
200.00		Cross Foot Adjustments	0				0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118 through 201)	39,818,290	4,630,905	763,862	1,215,537	167,137

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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE - BILLING						5.01
5.02	00591	ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	464,800					9.00
10.00	01000	DIETARY	24,238	663,459				10.00
11.00	01100	CAFETERIA	0	551,909	551,909			11.00
13.00	01300	NURSING ADMINISTRATION	1,426	0	26,449	714,321		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,852	0	0	0	20,592	14.00
15.00	01500	PHARMACY	4,277	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,129	0	19,396	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	96,951	96,738	74,058	167,950	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,832	14,812	17,633	63,964	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,476	0	22,923	50,144	0	50.00
51.00	05100	RECOVERY ROOM	1,426	0	0	7,940	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	3,527	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,664	0	61,715	3,380	0	54.00
60.00	06000	LABORATORY	18,535	0	70,532	0	0	60.00
66.00	06600	PHYSICAL THERAPY	27,090	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	15,683	0	12,343	42,080	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	6,817	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	28,213	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	31,367	0	75,820	76,919	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	54,179	0	10,580	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	59,882	0	63,478	156,790	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	31,739	145,154	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	432,007	663,459	518,406	714,321	20,592	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,426	0	28,213	0	0	192.00
192.01	19201	WELLNESS CENTER	31,367	0	5,290	0	0	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	0	0	0	192.03
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)	464,800	663,459	551,909	714,321	20,592	202.00

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE - BILLING					5.01
5.02	00591	ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	4,163				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	815,362			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	173,914	0	2,632,141	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,740	0	924,243	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	219,846	0	1,578,772	50.00
51.00	05100	RECOVERY ROOM	0	0	0	120,437	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	59,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	65,434	0	2,884,822	54.00
60.00	06000	LABORATORY	0	75,378	0	2,728,894	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,315,330	66.00
69.00	06900	ELECTROCARDIOLOGY	0	43,495	0	729,116	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	627,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,251,721	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,163	0	0	2,659,791	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	1,314,087	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	10,749,789	88.00
90.00	09000	CLINIC	0	0	0	2,490,903	90.00
91.00	09100	EMERGENCY	0	107,517	0	2,919,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	118,038	0	1,747,492	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	31,647	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,163	815,362	0	36,766,505	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	12,164	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,550,337	192.00
192.01	19201	WELLNESS CENTER	0	0	0	1,228,395	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	0	260,889	192.03
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)	4,163	815,362	0	39,818,290	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	BUSINESS OFFICE - BILLING	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	97.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	WELLNESS CENTER	192.01
192.03	19203	COMMUNITY RELATIONS	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0059

Period:
From 07/01/2019
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,999	0	1,999	4.00
5.01	00590	BUSINESS OFFICE - BILLING	0	6,905	573	7,478	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	0	148,805	382,645	531,450	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	43,093	0	43,093	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,225	1,945	6,170	8.00
9.00	00900	HOUSEKEEPING	0	2,650	0	2,650	9.00
10.00	01000	DIETARY	0	25,082	1,704	26,786	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,999	0	1,999	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,838	0	4,838	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,523	51,455	61,978	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	42,987	20,389	63,376	30.00
31.00	03100	INTENSIVE CARE UNIT	0	15,990	2,477	18,467	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	31,230	103,934	135,164	50.00
51.00	05100	RECOVERY ROOM	0	2,960	0	2,960	51.00
53.00	05300	ANESTHESIOLOGY	0	1,181	0	1,181	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48,862	180,372	229,234	54.00
60.00	06000	LABORATORY	0	22,485	33,059	55,544	60.00
66.00	06600	PHYSICAL THERAPY	0	23,863	1,578	25,441	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,357	30,701	53,058	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,366	32,471	40,837	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	26,793	10,904	37,697	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	262,148	28,596	290,744	88.00
90.00	09000	CLINIC	0	42,048	58,706	100,754	90.00
91.00	09100	EMERGENCY	0	50,036	5,459	55,495	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	36,605	53,954	90,559	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	888,030	1,000,922	1,888,952	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,869	0	3,869	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	98,694	6,848	105,542	192.00
192.01	19201	WELLNESS CENTER	0	193,041	17,439	210,480	192.01
192.03	19203	COMMUNITY RELATIONS	0	681	0	681	192.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers				0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,184,315	1,025,209	2,209,524	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0059

Period:
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Cost Center Description		BUSINESS OFFICE - BILLING	ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.01	5.02	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00500	BUSINESS OFFICE - BILLING	7,505				5.01
5.02	00501	ADMINISTRATIVE AND GENERAL	0	531,656			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	10,199	53,317		6.00
7.00	00700	OPERATION OF PLANT	0	16,230	0	16,242	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,118	229	70	8.00
9.00	00900	HOUSEKEEPING	0	5,990	144	44	9.00
10.00	01000	DIETARY	0	7,861	1,360	414	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	9,112	108	33	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	102	262	80	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,250	570	174	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	211	25,133	2,330	710	30.00
31.00	03100	INTENSIVE CARE UNIT	36	10,234	867	264	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	332	15,549	1,693	516	50.00
51.00	05100	RECOVERY ROOM	17	1,403	160	49	51.00
53.00	05300	ANESTHESIOLOGY	176	719	64	20	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,961	34,914	2,649	807	54.00
60.00	06000	LABORATORY	1,253	33,636	1,219	371	60.00
66.00	06600	PHYSICAL THERAPY	469	16,559	1,294	394	66.00
69.00	06900	ELECTROCARDIOLOGY	251	7,605	1,212	369	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	104	8,289	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	87	16,529	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	409	34,856	454	138	73.00
75.00	07500	ASC (NON-DISTINCT PART)	175	14,193	1,452	442	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	758	135,621	14,213	4,329	88.00
90.00	09000	CLINIC	364	32,128	2,279	694	90.00
91.00	09100	EMERGENCY	743	32,011	2,712	826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	159	18,411	1,984	605	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	423	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	7,505	500,075	37,255	11,349	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	58	210	64	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	17,604	5,350	1,630	192.00
192.01	19201	WELLNESS CENTER	0	10,454	10,465	3,188	192.01
192.03	19203	COMMUNITY RELATIONS	0	3,465	37	11	192.03
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)	7,505	531,656	53,317	16,242	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0059

Period:
From 07/01/2019
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Cost Center Description			HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	BUSINESS OFFICE - BILLING						5.01
5.02	00591	ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	9,407					9.00
10.00	01000	DIETARY	491	36,943				10.00
11.00	01100	CAFETERIA	0	30,731	30,731			11.00
13.00	01300	NURSING ADMINISTRATION	29	0	1,473	12,797		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	58	0	0	0	5,360	14.00
15.00	01500	PHARMACY	87	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	144	0	1,080	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,961	5,387	4,124	3,009	0	30.00
31.00	03100	INTENSIVE CARE UNIT	260	825	982	1,146	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	981	0	1,276	898	0	50.00
51.00	05100	RECOVERY ROOM	29	0	0	142	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	196	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	519	0	3,436	61	0	54.00
60.00	06000	LABORATORY	375	0	3,927	0	0	60.00
66.00	06600	PHYSICAL THERAPY	548	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	317	0	687	754	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,774	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	3,586	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,571	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	635	0	4,222	1,378	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,097	0	589	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,212	0	3,535	2,809	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	1,767	2,600	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,743	36,943	28,865	12,797	5,360	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	29	0	1,571	0	0	192.00
192.01	19201	WELLNESS CENTER	635	0	295	0	0	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	0	0	0	192.03
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)	9,407	36,943	30,731	12,797	5,360	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0059

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From 07/01/2019
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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		15.00	16.00	19.00	24.00	25.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE - BILLING					5.01
5.02	00591	ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY	85				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,226			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	15,832		124,945	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,069		34,435	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	20,013		176,971	50.00
51.00	05100	RECOVERY ROOM	0	0		4,766	51.00
53.00	05300	ANESTHESIOLOGY	0	0		2,356	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,957		280,420	54.00
60.00	06000	LABORATORY	0	6,862		103,278	60.00
66.00	06600	PHYSICAL THERAPY	0	0		44,705	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,959		68,289	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		10,167	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		20,202	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	85	0		78,399	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		60,920	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0		447,958	88.00
90.00	09000	CLINIC	0	0		136,364	90.00
91.00	09100	EMERGENCY	0	9,788		111,070	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	10,746		126,909	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0		423	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	85	74,226	0	1,832,577	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		4,201	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		131,966	192.00
192.01	19201	WELLNESS CENTER	0	0		236,584	192.01
192.03	19203	COMMUNITY RELATIONS	0	0		4,194	192.03
200.00		Cross Foot Adjustments			0	0	200.00
201.00		Negative Cost Centers	2	0	0	2	201.00
202.00		TOTAL (sum lines 118 through 201)	87	74,226	0	2,209,524	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.01	00590	BUSINESS OFFICE - BILLING	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	5.02
6.00	00600	MAINTENANCE & REPAIRS	6.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	19.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
60.00	06000	LABORATORY	60.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
90.00	09000	CLINIC	90.00
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	97.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	WELLNESS CENTER	192.01
192.03	19203	COMMUNITY RELATIONS	192.03
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	BUSINESS OFFICE - BILLING (GROSS CHARGES)	Reconciliation	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	156,431					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,023,822				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	264	0	20,970,470			4.00
5.01	00590	BUSINESS OFFICE - BILLING	912	572	281,628	100,512,158		5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	19,655	382,129	2,170,263	0	-4,630,905	5.02
6.00	00600	MAINTENANCE & REPAIRS	5,692	0	262,126	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	128,977	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	558	1,942	33,562	0	0	8.00
9.00	00900	HOUSEKEEPING	350	0	235,193	0	0	9.00
10.00	01000	DIETARY	3,313	1,702	321,566	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	264	0	454,787	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	639	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	114	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,390	51,385	314,539	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,678	20,361	1,173,424	2,814,680	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,112	2,474	507,152	482,890	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,125	103,793	371,037	4,431,193	0	50.00
51.00	05100	RECOVERY ROOM	391	0	67,570	230,394	0	51.00
53.00	05300	ANESTHESIOLOGY	156	0	3,571	2,344,132	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,454	180,128	994,605	26,581,568	0	54.00
60.00	06000	LABORATORY	2,970	33,014	962,128	16,707,749	0	60.00
66.00	06600	PHYSICAL THERAPY	3,152	1,576	0	6,259,760	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,953	30,659	313,898	3,345,222	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,384,414	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,156,193	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,105	32,427	515,486	5,453,590	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,539	10,889	592,058	2,332,907	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	34,626	28,557	6,058,882	10,112,030	0	88.00
90.00	09000	CLINIC	5,554	58,627	1,522,940	4,852,331	0	90.00
91.00	09100	EMERGENCY	6,609	5,452	2,001,590	9,900,582	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,835	53,881	819,438	2,121,845	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	678	0	97.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,296	999,568	20,106,420	100,512,158	-4,630,791	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	511	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,036	6,839	600,163	0	0	192.00
192.01	19201	WELLNESS CENTER	25,498	17,415	263,887	0	0	192.01
192.03	19203	COMMUNITY RELATIONS	90	0	0	0	0	192.03
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,184,315	1,025,209	3,993,998	896,692		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.570846	1.001355	0.190458	0.008921		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,999	7,505		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000095	0.000075		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description		ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.02	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE - BILLING					5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	35,187,499				5.02
6.00	00600	MAINTENANCE & REPAIRS	675,024	129,908			6.00
7.00	00700	OPERATION OF PLANT	1,074,169	0	129,908		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	140,186	558	558	7,136	8.00
9.00	00900	HOUSEKEEPING	396,448	350	350	463	9.00
10.00	01000	DIETARY	520,270	3,313	3,313	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	603,057	264	264	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,721	639	639	17	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	678,379	1,390	1,390	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,663,414	5,678	5,678	2,292	30.00
31.00	03100	INTENSIVE CARE UNIT	677,326	2,112	2,112	197	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,029,094	4,125	4,125	427	50.00
51.00	05100	RECOVERY ROOM	92,888	391	391	0	51.00
53.00	05300	ANESTHESIOLOGY	47,616	156	156	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,310,828	6,454	6,454	655	54.00
60.00	06000	LABORATORY	2,226,210	2,970	2,970	0	60.00
66.00	06600	PHYSICAL THERAPY	1,095,975	3,152	3,152	0	66.00
69.00	06900	ELECTROCARDIOLOGY	503,361	2,953	2,953	39	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	548,599	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,093,972	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,306,966	1,105	1,105	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	939,383	3,539	3,539	557	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,975,757	34,626	34,626	18	88.00
90.00	09000	CLINIC	2,126,425	5,554	5,554	0	90.00
91.00	09100	EMERGENCY	2,118,684	6,609	6,609	1,453	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,218,524	4,835	4,835	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	27,966	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	33,097,242	90,773	90,773	6,118	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,869	511	511	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,165,165	13,036	13,036	152	192.00
192.01	19201	WELLNESS CENTER	691,887	25,498	25,498	866	192.01
192.03	19203	COMMUNITY RELATIONS	229,336	90	90	0	192.03
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,630,905	763,862	1,215,537	167,137	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.131607	5.880023	9.356906	23.421665	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	531,656	53,317	16,242	8,590	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.015109	0.410421	0.125027	1.203756	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				28.855828	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	BUSINESS OFFICE - BILLING					5.01
5.02	00591	ADMINISTRATIVE AND GENERAL					5.02
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY	53,303				10.00
11.00	01100	CAFETERIA	44,341	313			11.00
13.00	01300	NURSING ADMINISTRATION	0	15	190,004		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,619,907	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	7,772	42	44,673	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,190	10	17,014	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	13	13,338	0	50.00
51.00	05100	RECOVERY ROOM	0	0	2,112	0	51.00
53.00	05300	ANESTHESIOLOGY	0	2	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35	899	0	54.00
60.00	06000	LABORATORY	0	40	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	7	11,193	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	536,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,083,658	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	16	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	43	20,460	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	36	41,705	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	18	38,610	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	53,303	294	190,004	1,619,907	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	16	0	0	192.00
192.01	19201	WELLNESS CENTER	0	3	0	0	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	0	0	192.03
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)	663,459	551,909	714,321	20,592	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.446935	1,763.287540	3.759505	0.012712	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,943	30,731	12,797	5,360	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.693075	98.182109	0.067351	0.003309	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet B-1
Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		16.00	19.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00590	BUSINESS OFFICE - BILLING		5.01
5.02	00591	ADMINISTRATIVE AND GENERAL		5.02
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	12,710	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,711	30.00
31.00	03100	INTENSIVE CARE UNIT	183	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,427	50.00
51.00	05100	RECOVERY ROOM	0	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,020	54.00
60.00	06000	LABORATORY	1,175	60.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	678	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	75.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	1,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,840	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	97.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	12,710	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	WELLNESS CENTER	0	192.01
192.03	19203	COMMUNITY RELATIONS	0	192.03
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)	815,362	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	64.151220	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,226	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	5.839969	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES				Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 2/1/2021 2:11 pm		
				Title XVIII	Hospital	PPS		
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	2,632,141		2,632,141	0	2,632,141	30.00
31.00	03100	INTENSIVE CARE UNIT	924,243		924,243	0	924,243	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,578,772		1,578,772	0	1,578,772	50.00
51.00	05100	RECOVERY ROOM	120,437		120,437	0	120,437	51.00
53.00	05300	ANESTHESIOLOGY	59,787		59,787	0	59,787	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,884,822		2,884,822	0	2,884,822	54.00
60.00	06000	LABORATORY	2,728,894		2,728,894	0	2,728,894	60.00
66.00	06600	PHYSICAL THERAPY	1,315,330	0	1,315,330	0	1,315,330	66.00
69.00	06900	ELECTROCARDIOLOGY	729,116		729,116	0	729,116	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	627,615		627,615	0	627,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,251,721		1,251,721	0	1,251,721	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,659,791		2,659,791	0	2,659,791	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,314,087		1,314,087	0	1,314,087	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,749,789		10,749,789	0	10,749,789	88.00
90.00	09000	CLINIC	2,490,903		2,490,903	0	2,490,903	90.00
91.00	09100	EMERGENCY	2,919,918		2,919,918	0	2,919,918	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	847,403		847,403	0	847,403	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,747,492		1,747,492	0	1,747,492	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	31,647		31,647	0	31,647	97.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	37,613,908	0	37,613,908	0	37,613,908	200.00
201.00		Less Observation Beds	847,403		847,403		847,403	201.00
202.00		Total (see instructions)	36,766,505	0	36,766,505	0	36,766,505	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

					Title XVIII		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
			Inpatient	Outpatient	Total (col. 6 + col. 7)					
			6.00	7.00	8.00					
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	1,383,865		1,383,865			30.00		
31.00	03100	INTENSIVE CARE UNIT	482,890		482,890			31.00		
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	558,396	3,872,797	4,431,193	0.356286	0.000000	50.00		
51.00	05100	RECOVERY ROOM	43,120	187,274	230,394	0.522744	0.000000	51.00		
53.00	05300	ANESTHESIOLOGY	249,433	2,094,699	2,344,132	0.025505	0.000000	53.00		
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,223,044	25,358,524	26,581,568	0.108527	0.000000	54.00		
60.00	06000	LABORATORY	1,346,230	15,361,519	16,707,749	0.163331	0.000000	60.00		
66.00	06600	PHYSICAL THERAPY	538,596	5,721,164	6,259,760	0.210125	0.000000	66.00		
69.00	06900	ELECTROCARDIOLOGY	474,332	2,870,890	3,345,222	0.217957	0.000000	69.00		
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	594,702	789,712	1,384,414	0.453343	0.000000	71.00		
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	430,796	725,397	1,156,193	1.082623	0.000000	72.00		
73.00	07300	DRUGS CHARGED TO PATIENTS	1,083,289	4,370,301	5,453,590	0.487714	0.000000	73.00		
75.00	07500	ASC (NON-DISTINCT PART)	63,469	2,269,438	2,332,907	0.563283	0.000000	75.00		
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	10,112,030	10,112,030			88.00		
90.00	09000	CLINIC	0	4,852,331	4,852,331	0.513342	0.000000	90.00		
91.00	09100	EMERGENCY	1,230,530	8,670,052	9,900,582	0.294924	0.000000	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	94,014	1,336,801	1,430,815	0.592252	0.000000	92.00		
	OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	2,121,845	2,121,845	0.823572	0.000000	95.00		
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	678	678	46.676991	0.000000	97.00		
	SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE						113.00		
200.00		Subtotal (see instructions)	9,796,706	90,715,452	100,512,158			200.00		
201.00		Less Observation Beds						201.00		
202.00		Total (see instructions)	9,796,706	90,715,452	100,512,158			202.00		

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
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2/1/2021 2:11 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.356286			50.00
51.00	05100 RECOVERY ROOM	0.522744			51.00
53.00	05300 ANESTHESIOLOGY	0.025505			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.108527			54.00
60.00	06000 LABORATORY	0.163331			60.00
66.00	06600 PHYSICAL THERAPY	0.210125			66.00
69.00	06900 ELECTROCARDIOLOGY	0.217957			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453343			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.082623			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.487714			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.563283			75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.513342			90.00
91.00	09100 EMERGENCY	0.294924			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.592252			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.823572			95.00
97.00	09700 DURABLE MEDICAL EQUIP. - SOLD	46.676991			97.00
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,632,141		2,632,141	0	2,632,141	30.00	
31.00	03100	INTENSIVE CARE UNIT	924,243		924,243	0	924,243	31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,578,772		1,578,772	0	1,578,772	50.00	
51.00	05100	RECOVERY ROOM	120,437		120,437	0	120,437	51.00	
53.00	05300	ANESTHESIOLOGY	59,787		59,787	0	59,787	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,884,822		2,884,822	0	2,884,822	54.00	
60.00	06000	LABORATORY	2,728,894		2,728,894	0	2,728,894	60.00	
66.00	06600	PHYSICAL THERAPY	1,315,330	0	1,315,330	0	1,315,330	66.00	
69.00	06900	ELECTROCARDIOLOGY	729,116		729,116	0	729,116	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	627,615		627,615	0	627,615	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,251,721		1,251,721	0	1,251,721	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	2,659,791		2,659,791	0	2,659,791	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	1,314,087		1,314,087	0	1,314,087	75.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	10,749,789		10,749,789	0	10,749,789	88.00	
90.00	09000	CLINIC	2,490,903		2,490,903	0	2,490,903	90.00	
91.00	09100	EMERGENCY	2,919,918		2,919,918	0	2,919,918	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	847,403		847,403		847,403	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,747,492		1,747,492	0	1,747,492	95.00	
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	31,647		31,647	0	31,647	97.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	37,613,908	0	37,613,908	0	37,613,908	200.00	
201.00		Less Observation Beds	847,403		847,403		847,403	201.00	
202.00		Total (see instructions)	36,766,505	0	36,766,505	0	36,766,505	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet C
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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	1,383,865		1,383,865		30.00
31.00	03100	INTENSIVE CARE UNIT	482,890		482,890		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	558,396	3,872,797	4,431,193	0.356286	50.00
51.00	05100	RECOVERY ROOM	43,120	187,274	230,394	0.522744	51.00
53.00	05300	ANESTHESIOLOGY	249,433	2,094,699	2,344,132	0.025505	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,223,044	25,358,524	26,581,568	0.108527	54.00
60.00	06000	LABORATORY	1,346,230	15,361,519	16,707,749	0.163331	60.00
66.00	06600	PHYSICAL THERAPY	538,596	5,721,164	6,259,760	0.210125	66.00
69.00	06900	ELECTROCARDIOLOGY	474,332	2,870,890	3,345,222	0.217957	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	594,702	789,712	1,384,414	0.453343	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	430,796	725,397	1,156,193	1.082623	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,083,289	4,370,301	5,453,590	0.487714	73.00
75.00	07500	ASC (NON-DISTINCT PART)	63,469	2,269,438	2,332,907	0.563283	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	10,112,030	10,112,030	1.063069	88.00
90.00	09000	CLINIC	0	4,852,331	4,852,331	0.513342	90.00
91.00	09100	EMERGENCY	1,230,530	8,670,052	9,900,582	0.294924	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	94,014	1,336,801	1,430,815	0.592252	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	2,121,845	2,121,845	0.823572	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	678	678	46.676991	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	9,796,706	90,715,452	100,512,158		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	9,796,706	90,715,452	100,512,158		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
51.00	05100 RECOVERY ROOM	0.000000			51.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000			75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
90.00	09000 CLINIC	0.000000			90.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.000000			95.00
97.00	09700 DURABLE MEDICAL EQUIP. - SOLD	0.000000			97.00
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:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	124,945	891	124,054	2,754	45.05	30.00	
31.00	INTENSIVE CARE UNIT	34,435		34,435	283	121.68	31.00	
200.00	Total (lines 30 through 199)	159,380		158,489	3,037		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	1,120	50,456					30.00
31.00	INTENSIVE CARE UNIT	187	22,754					31.00
200.00	Total (lines 30 through 199)	1,307	73,210					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 2/1/2021 2:11 pm
Title XVIII				Hospital		PPS
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	176,971	4,431,193	0.039938	490,347	19,583	50.00
51.00 05100 RECOVERY ROOM	4,766	230,394	0.020686	24,554	508	51.00
53.00 05300 ANESTHESIOLOGY	2,356	2,344,132	0.001005	95,443	96	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	280,420	26,581,568	0.010549	1,223,044	12,902	54.00
60.00 06000 LABORATORY	103,278	16,707,749	0.006181	1,340,089	8,283	60.00
66.00 06600 PHYSICAL THERAPY	44,705	6,259,760	0.007142	355,609	2,540	66.00
69.00 06900 ELECTROCARDIOLOGY	68,289	3,345,222	0.020414	364,432	7,440	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10,167	1,384,414	0.007344	172,581	1,267	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20,202	1,156,193	0.017473	245,759	4,294	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	78,399	5,453,590	0.014376	736,821	10,593	73.00
75.00 07500 ASC (NON-DISTINCT PART)	60,920	2,332,907	0.026113	35,327	922	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	447,958	10,112,030	0.044300	0	0	88.00
90.00 09000 CLINIC	136,364	4,852,331	0.028103	0	0	90.00
91.00 09100 EMERGENCY	111,070	9,900,582	0.011219	771,790	8,659	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	40,225	1,430,815	0.028113	41,499	1,167	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDICAL EQUIP. - SOLD	423	678	0.623894	0	0	97.00
200.00 Total (lines 50 through 199)	1,586,513	96,523,558		5,897,295	78,254	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS				SP Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 2/1/2021 2:11 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
				1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00
Cost Center Description				Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
				4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	2,754	0.00	1,120	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	283	0.00	187	31.00	
200.00		Total (lines 30 through 199)		0	3,037		1,307	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
31.00	03100	INTENSIVE CARE UNIT	0						31.00
200.00		Total (lines 30 through 199)	0						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 2/1/2021 2:11 pm	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 2/1/2021 2:11 pm	
Cost Center Description				Title XVIII		Hospital		PPS	
				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	4,431,193	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	230,394	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,344,132	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	26,581,568	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	0	16,707,749	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	6,259,760	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3,345,222	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1,384,414	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,156,193	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	5,453,590	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	2,332,907	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	10,112,030	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0	4,852,331	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	0	9,900,582	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	1,430,815	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	0	678	0.000000	97.00
200.00		Total (lines 50 through 199)	0	0	0	0	96,523,558		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	490,347	0	1,502,103	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	24,554	0	69,583	0	51.00
53.00	05300	ANESTHESIOLOGY	0.000000	95,443	0	338,715	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,223,044	0	9,771,552	0	54.00
60.00	06000	LABORATORY	0.000000	1,340,089	0	2,102,078	0	60.00
66.00	06600	PHYSICAL THERAPY	0.000000	355,609	0	45,316	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	364,432	0	943,516	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	172,581	0	132,890	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	245,759	0	406,050	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	736,821	0	2,524,050	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	35,327	0	1,711,926	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	126,688	0	90.00
91.00	09100	EMERGENCY	0.000000	771,790	0	2,680,721	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	41,499	0	668,947	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0.000000	0	0	0	0	97.00
200.00		Total (lines 50 through 199)		5,897,295	0	23,024,135	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 2/1/2021 2:11 pm
			Title XVIII	Hospital	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.356286	1,502,103	0	0	535,178
51.00 05100 RECOVERY ROOM	0.522744	69,583	0	0	36,374
53.00 05300 ANESTHESIOLOGY	0.025505	338,715	0	0	8,639
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.108527	9,771,552	0	0	1,060,477
60.00 06000 LABORATORY	0.163331	2,102,078	0	0	343,335
66.00 06600 PHYSICAL THERAPY	0.210125	45,316	0	0	9,522
69.00 06900 ELECTROCARDIOLOGY	0.217957	943,516	0	0	205,646
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453343	132,890	0	0	60,245
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1.082623	406,050	0	0	439,599
73.00 07300 DRUGS CHARGED TO PATIENTS	0.487714	2,524,050	0	15,341	1,231,015
75.00 07500 ASC (NON-DISTINCT PART)	0.563283	1,711,926	0	98	964,299
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					
90.00 09000 CLINIC	0.513342	126,688	0	0	65,034
91.00 09100 EMERGENCY	0.294924	2,680,721	0	0	790,609
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.592252	668,947	0	0	396,185
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.823572		0		
97.00 09700 DURABLE MEDICAL EQUIP. - SOLD	46.676991	0	0	0	0
200.00 Subtotal (see instructions)		23,024,135	0	15,439	6,146,157
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00 Net Charges (line 200 - line 201)		23,024,135	0	15,439	6,146,157

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
2/1/2021 2:11 pm

				Title XVIII	Hospital	PPS
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,482		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	55		75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0		97.00
200.00		Subtotal (see instructions)	0	7,537		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	7,537		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 2/1/2021 2:11 pm
			Component CCN:14-U059		
			Title XVIII	Swing Beds - SNF	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.356286	0	0	0	0 50.00
51.00 05100 RECOVERY ROOM	0.522744	0	0	0	0 51.00
53.00 05300 ANESTHESIOLOGY	0.025505	0	0	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.108527	0	0	0	0 54.00
60.00 06000 LABORATORY	0.163331	0	0	0	0 60.00
66.00 06600 PHYSICAL THERAPY	0.210125	0	0	0	0 66.00
69.00 06900 ELECTROCARDIOLOGY	0.217957	0	0	0	0 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453343	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1.082623	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.487714	0	0	0	0 73.00
75.00 07500 ASC (NON-DISTINCT PART)	0.563283	0	0	0	0 75.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88.00
90.00 09000 CLINIC	0.513342	0	0	0	0 90.00
91.00 09100 EMERGENCY	0.294924	0	0	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.592252	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.823572		0		95.00
97.00 09700 DURABLE MEDICAL EQUIP. - SOLD	46.676991	0	0	0	0 97.00
200.00 Subtotal (see instructions)		0	0	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	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part V Date/Time Prepared: 2/1/2021 2:11 pm
		Component CCN:14-U059		
		Title XVIII	Swing Beds - SNF	PPS

Cost Center Description			Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0		95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	97.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 2/1/2021 2:11 pm	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,836	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,754	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			1,861	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			112	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)			-30	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			1,120	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)			44	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)			28	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			231.33	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			237.99	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			157.19	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			157.19	20.00
21.00	Total general inpatient routine service cost (see instructions)			2,632,141	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)			25,909	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)			-7,140	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)			18,769	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,613,372	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 22,613,372 minus line 36)			27,613,372	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)			948.94	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,062,813	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)			1,062,813	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 2/1/2021 2:11 pm	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	924,243	283	3,265.88	187	610,720	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,671,493	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,345,026	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)					73,210	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					78,254	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					151,464	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,193,562	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)					10,179	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					6,664	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					16,843	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)					893	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					948.94	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					847,403	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN:14-0059		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 2/1/2021 2:11 pm	
		Title XVIII		Hospital		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	124,945	2,632,141	0.047469	847,403	40,225	90.00
91.00	Nursing School cost	0	2,632,141	0.000000	847,403	0	91.00
92.00	Allied health cost	0	2,632,141	0.000000	847,403	0	92.00
93.00	All other Medical Education	0	2,632,141	0.000000	847,403	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 2/1/2021 2:11 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		663,408	30.00
31.00	03100	INTENSIVE CARE UNIT		251,152	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.356286	490,347	50.00
51.00	05100	RECOVERY ROOM	0.522744	24,554	51.00
53.00	05300	ANESTHESIOLOGY	0.025505	95,443	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108527	1,223,044	54.00
60.00	06000	LABORATORY	0.163331	1,340,089	60.00
66.00	06600	PHYSICAL THERAPY	0.210125	355,609	66.00
69.00	06900	ELECTROCARDIOLOGY	0.217957	364,432	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453343	172,581	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.082623	245,759	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.487714	736,821	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.563283	35,327	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.513342	0	90.00
91.00	09100	EMERGENCY	0.294924	771,790	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.592252	41,499	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	46.676991	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,897,295	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		5,897,295	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-0059

Period:

Worksheet D-3

Component CCN:14-U059

From 07/01/2019
To 06/30/2020Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description		Title XVIII	Swing Beds - SNF	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.356286	0	50.00
51.00	05100	RECOVERY ROOM	0.522744	0	51.00
53.00	05300	ANESTHESIOLOGY	0.025505	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.108527	0	54.00
60.00	06000	LABORATORY	0.163331	1,130	60.00
66.00	06600	PHYSICAL THERAPY	0.210125	38,817	66.00
69.00	06900	ELECTROCARDIOLOGY	0.217957	5,956	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.453343	2,218	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.082623	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.487714	10,642	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.563283	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.513342	0	90.00
91.00	09100	EMERGENCY	0.294924	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.592252	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	46.676991	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		58,763	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		58,763	202.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 2/1/2021 2:11 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0	1.00	
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	614,256		1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	\$874,360		1.02	
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0		1.03	
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0		1.04	
2.00	Outlier payments for discharges. (see instructions)			2.00	
2.01	Outlier reconciliation amount	0		2.01	
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0		2.02	
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0		2.03	
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	0		2.04	
3.00	Managed Care Simulated Payments	0		3.00	
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	43.34		4.00	
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00	
6.00	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)		0.00	6.00	
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00	
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 then see instructions.		0.00	7.01	
8.00	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).		0.00	8.00	
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.		0.00	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)		0.00	8.02	
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00	
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00	
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00	
12.00	Current year allowable FTE (see instructions)		0.00	12.00	
13.00	Total allowable FTE count for the prior year.		0.00	13.00	
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00	
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00	
16.00	Adjustment for residents in initial years of the program		0.00	16.00	
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00	
18.00	Adjusted rolling average FTE count		0.00	18.00	
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00	
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00	
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00	
22.00	IME payment adjustment (see instructions)		0	22.00	
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01	
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00	
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00	
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00	
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00	
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00	
28.00	IME add-on adjustment amount (see instructions)		0	28.00	
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01	
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01	
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.33	30.00	
31.00	Percentage of Medicaid patient days (see instructions)		0.00	31.00	
32.00	Sum of lines 30 and 31		4.33	32.00	
33.00	Allowable disproportionate share percentage (see instructions)		0.00	33.00	
34.00	Disproportionate share adjustment (see instructions)		0	34.00	

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 2/1/2021 2:11 pm
			Title XVIII	Hospital	PPS
				Prior to 10/1	On/After 10/1
				1.00	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)			0	0 35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000000000	0 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			0	0 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			0	0 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)			0	0 36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)			0	0 40.00
				Before 1/1	On/After 1/1
				1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	0 41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	0 41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		0 42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)			0	0 43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		0 44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	0 45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)			0	0 46.00
47.00	Subtotal (see instructions)		2,488,616		0 47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		885,526		0 48.00
					Amount
					1.00
49.00	Total payment for inpatient operating costs (see instructions)			2,786,299	0 49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			196,493	0 50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	0 51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	0 52.00
53.00	Nursing and Allied Health Managed Care payment			0	0 53.00
54.00	Special add-on payments for new technologies			0	0 54.00
54.01	Islet isolation add-on payment			0	0 54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	0 55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	0 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	0 57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	0 58.00
59.00	Total (sum of amounts on lines 49 through 58)			2,982,792	0 59.00
60.00	Primary payer payments			0	0 60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			2,982,792	0 61.00
62.00	Deductibles billed to program beneficiaries			401,588	0 62.00
63.00	Coinurance billed to program beneficiaries			3,751	0 63.00
64.00	Allowable bad debts (see instructions)			145,305	0 64.00
65.00	Adjusted reimbursable bad debts (see instructions)			94,448	0 65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			122,939	0 66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			2,671,901	0 67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	0 68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	0 69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	0 70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	0 70.50
70.87	Demonstration payment adjustment amount before sequestration			0	0 70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	0 70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				0 70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			510	0 70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-850	0 70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	0 70.92
70.93	HVBP payment adjustment amount (see instructions)			4,276	0 70.93
70.94	HRR adjustment amount (see instructions)			-7,075	0 70.94
70.95	Recovery of accelerated depreciation			0	0 70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 2/1/2021 2:11 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2018	112,811	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2019	491,130	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		3,272,703	71.00
71.01	Sequestration adjustment (see instructions)		54,654	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		3,337,668	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-119,619	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		74,827	222,856
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	1.0009528966	1.0019690250	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	71	439	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.9955	0.9977	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-337	-513	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/1/2021 2:11 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	614,256	0	614,256		614,256	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,874,360	0		1,874,360	1,874,360	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,488,616	0	614,256	1,874,360	2,488,616	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,885,526	0	713,543	2,171,983	2,885,526	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,786,299	0	688,721	2,097,578	2,786,299	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	196,493	0	49,294	147,199	196,493	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ acquisition cost							17.01

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/1/2021 2:11 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	738,015	2,244,777	2,982,792
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	196,493	0	49,294	147,199	196,493
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000	
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	196,493	0	49,294	147,199	196,493
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.152857	0.218788	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			112,811		112,811
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				491,130	491,130
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/1/2021 2:11 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	614,256	614,256		614,256	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1,874,360		1,874,360	1,874,360	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0000	0.0000	0.0000		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	0	11.00
11.01	Uncompensated care payments	36.00	0	0	0	0	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	2,488,616	614,256	1,874,360	2,488,616	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	2,885,526	713,543	2,171,983	2,885,526	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	2,786,299	688,721	2,097,578	2,786,299	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	196,493	49,294	147,199	196,493	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			738,015	2,244,777	2,982,792	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/1/2021 2:11 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	196,493	49,294	147,199	196,493	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	196,493	49,294	147,199	196,493	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	112,811	112,811		112,811	28.00
29.00	Low volume adjustment on or after October 1	70.97	491,130		491,130	491,130	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	4,276	585	3,691	4,276	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	510	71	439	510	30.01
31.00	HRR adjustment (see instructions)	70.94	-7,075	-2,764	-4,311	-7,075	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-850	-337	-513	-850	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 2/1/2021 2:11 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)			7,537	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			6,146,157	2.00
3.00	OPPS payments			5,223,414	3.00
4.00	Outlier payment (see instructions)			2,421	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7,537	11.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges			15,439	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			15,439	14.00
Customary charges					
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			15,439	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			7,902	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0	20.00
21.00	Lesser of cost or charges (see instructions)			7,537	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			5,225,835	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,036,478	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			4,196,894	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			4,196,894	30.00
31.00	Primary payer payments			309	31.00
32.00	Subtotal (line 30 minus line 31)			4,196,585	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)					
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			189,194	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			122,976	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			139,528	36.00
37.00	Subtotal (see instructions)			4,319,561	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			4,319,561	40.00
40.01	Sequestration adjustment (see instructions)			72,137	40.01
40.02	Demonstration payment adjustment amount after sequestration			0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			0	40.03
41.00	Interim payments			4,229,140	41.00
41.01	Interim payments-PARHM			0	41.01
42.00	Tentative settlement (for contractors use only)			0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			0	42.01
43.00	Balance due provider/program (see instructions)			18,284	43.00
43.01	Balance due provider/program-PARHM (see instructions)			0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0	44.00
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
2/1/2021 2:11 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,335,206		4,198,390	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	02/12/2020	2,462	02/12/2020	30,750	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		2,462		30,750	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,337,668		4,229,140	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		18,284	6.01
6.02	SETTLEMENT TO PROGRAM		119,619		0	6.02
7.00	Total Medicare program liability (see instructions)		3,218,049		4,247,424	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-0059

Period:

Worksheet E-1

Component CCN:14-U059

From 07/01/2019

Part I

To 06/30/2020

Date/Time Prepared:

2/1/2021 2:11 pm

		Title XVIII		Swing Beds - SNF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		26,896		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		26,896		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		90		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		26,986		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 2/1/2021 2:11 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet E-2	
		Component CCN:14-U059		Date/Time Prepared: 2/1/2021 2:11 pm	
		Title XVIII	Swing Beds - SNF	PPS	
			Part A	Part B	
			1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)		28,808	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	Part	0	0	3.00
3.01	Nursing and allied health payment-PARHM (see instructions)				3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)			0.00	4.00
5.00	Program days		72	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)			0	6.00
7.00	Utilization review - physician compensation - SNF optional method only		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		28,808	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		28,808	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0	0	11.00
12.00	Subtotal (line 10 minus line 11)		28,808	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		1,364	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		27,444	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)				16.50
16.55	Rural community hospital demonstration project (\$410A Demonstration) payment adjustment (see instructions)		0		16.55
16.99	Demonstration payment adjustment amount before sequestration		0	0	16.99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		27,444	0	19.00
19.01	Sequestration adjustment (see instructions)		458	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
20.00	Interim payments		26,896	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		90	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparison of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type provider CCN:14-0059 Period: From 07/01/2019 To 06/30/2020 Worksheet G Date/Time Prepared: 2/1/2021 2:11 pm)

		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	9,475,982	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	16,564,674	0	0	0	4.00
5.00	Other receivable	145,095	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,194,659	0	0	0	6.00
7.00	Inventory	778,261	0	0	0	7.00
8.00	Prepaid expenses	412,967	0	0	0	8.00
9.00	Other current assets	279,000	0	0	0	9.00
10.00	Due from other funds	12,563,829	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	28,025,149	0	0	0	11.00
FIXED ASSETS						
12.00	Land	55,000	0	0	0	12.00
13.00	Land improvements	104,998	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	22,300,576	0	0	0	15.00
16.00	Accumulated depreciation	-12,376,753	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	18,569,242	0	0	0	23.00
24.00	Accumulated depreciation	-15,251,144	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,401,919	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	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	68,786	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	68,786	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,495,854	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,741,453	0	0	0	37.00
38.00	Salaries, wages, and fees payable	967,750	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	905,099	0	0	0	40.00
41.00	Deferred income	7,362,285	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	5,843,057	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	16,819,644	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,802,726	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,689,355	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	8,492,081	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	25,311,725	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	16,184,129	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	16,184,129	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,495,854	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
2/1/2021 2:11 pm

		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		20,339,543		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-6,703,080				2.00
3.00	Total (sum of line 1 and line 2)		13,636,463		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)		13,636,463		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		13,636,463		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	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN:14-0059

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
2/1/2021 2:11 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	3,917,869		3,917,869	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)	3,917,869		3,917,869	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	578,036		578,036	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)	578,036		578,036	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,495,905		4,495,905	17.00
18.00	Ancillary services	6,675,763	67,537,866	74,213,629	18.00
19.00	Outpatient services	1,468,878	16,543,719	18,012,597	19.00
20.00	RURAL HEALTH CLINIC	0	9,946,520	9,946,520	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	-856	2,126,783	2,125,927	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIANS PRIVATE OFFICES	0	1,317,882	1,317,882	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)	6,312,639,690	97,472,770	110,112,460	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		47,996,714		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)		47,996,714		43.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST	In Lieu of Form CMS-2552-10	
STATEMENT OF REVENUES AND EXPENSES		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet G-3 Date/Time Prepared: 2/1/2021 2:11 pm
				1.00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)		110,112,460	1.00
2.00	Less contractual allowances and discounts on patients' accounts		72,369,954	2.00
3.00	Net patient revenues (line 1 minus line 2)		37,742,506	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		47,996,714	4.00
5.00	Net income from service to patients (line 3 minus line 4)		-10,254,208	5.00
OTHER INCOME				
6.00	Contributions, donations, bequests, etc		62,480	6.00
7.00	Income from investments		118,227	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		797	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		157,544	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		627,207	16.00
17.00	Revenue from sale of drugs to other than patients		0	17.00
18.00	Revenue from sale of medical records and abstracts		0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)		0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen		0	20.00
21.00	Rental of vending machines		0	21.00
22.00	Rental of hospital space		0	22.00
23.00	Governmental appropriations		0	23.00
24.00	WELLNESS CENTER		347,702	24.00
24.01	PROPERTY TAX AND REPLACEMENT TAXES		330,653	24.01
24.02	GRANT REVENUE		1,866,236	24.02
24.03	GAIN ON SALES OF ASSETS		0	24.03
24.04	POPULATION HEALTH		40,290	24.04
24.50	COVID-19 PHE Funding		0	24.50
25.00	Total other income (sum of lines 6-24)		3,551,136	25.00
26.00	Total (line 5 plus line 25)		-6,703,072	26.00
27.00	RECONILING ITEM		0	27.00
27.01	ROUNDING		8	27.01
28.00	Total other expenses (sum of line 27 and subscripts)		8	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)		-6,703,080	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 2/1/2021 2:11 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		196,493	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		5.86	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		196,493	12.00
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
		1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST			In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS				Provider CCN:14-0059	Period: From 07/01/2019	Worksheet M-1	
				Component CCN:14-8538	To 06/30/2020	Date/Time Prepared: 2/1/2021 2:11 pm	
				RHC I		Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassification ons	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	2,231,700	0	2,231,700	11,141	2,242,841	1.00
2.00	Physician Assistant	335,426	0	335,426	0	335,426	2.00
3.00	Nurse Practitioner	998,232	0	998,232	0	998,232	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	71,677	0	71,677	0	71,677	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,454,000	0	1,454,000	-134,692	1,319,308	9.00
10.00	Subtotal (sum of lines 1 through 9)	5,091,035	0	5,091,035	-123,551	4,967,484	10.00
11.00	Physician Services Under Agreement	0	40,400	40,400	0	40,400	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	40,400	40,400	0	40,400	14.00
15.00	Medical Supplies	0	372,066	372,066	-554	371,512	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	372,066	372,066	-554	371,512	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,091,035	412,466	5,503,501	-124,105	5,379,396	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	11,055	0	11,055	0	11,055	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	11,055	0	11,055	0	11,055	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	162,818	162,818	-5,025	157,793	29.00
30.00	Administrative Costs	1,187,746	1,146,938	2,334,684	-239,583	2,095,101	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,187,746	1,309,756	2,497,502	-244,608	2,252,894	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	6,289,836	1,722,222	8,012,058	-368,713	7,643,345	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-0059

Period:

Worksheet M-1

Component CCN:14-8538

From 07/01/2019
To 06/30/2020Date/Time Prepared:
2/1/2021 2:11 pm

RHC I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	2,242,841	1.00
2.00	Physician Assistant	0	335,426	2.00
3.00	Nurse Practitioner	-202,510	795,722	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	71,677	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	1,319,308	9.00
10.00	Subtotal (sum of lines 1 through 9)	-202,510	4,764,974	10.00
11.00	Physician Services Under Agreement	0	40,400	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	40,400	14.00
15.00	Medical Supplies	0	371,512	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	371,512	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-202,510	5,176,886	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
25.01	Telehealth	0	11,055	25.01
25.02	Chronic Care Management	0	0	25.02
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	11,055	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	157,793	29.00
30.00	Administrative Costs	0	2,095,101	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	2,252,894	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-202,510	7,440,835	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN:14-0059 Component CCN:14-8538	Period: From 07/01/2019 To 06/30/2020	Worksheet M-2 Date/Time Prepared: 2/1/2021 2:11 pm
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		RHC I		Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	7.98	32,288	4,200	33,516	1.00
2.00	Physician Assistant	2.40	8,496	2,100	5,040	2.00
3.00	Nurse Practitioner	7.33	24,354	2,100	15,393	3.00
4.00	Subtotal (sum of lines 1 through 3)	17.71	65,138		53,949	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.67	196		196	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	18.38	65,334		65,334	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				5,176,886	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				11,055	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				5,187,941	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.997869	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				2,252,894	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				3,308,954	15.00
16.00	Total overhead (sum of lines 14 and 15)				5,561,848	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				5,561,848	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				5,549,996	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				10,726,882	20.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet M-3	
		Component CCN:14-8538		Date/Time Prepared: 2/1/2021 2:11 pm	
		Title XVIII	RHC I	Cost	
			1.00		
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			10,726,882	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)			235,982	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)			10,490,900	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			65,334	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			65,334	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			160.57	7.00
			Calculation of Limit (1)		
			Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		84.70	86.31	8.00
9.00	Rate for Program covered visits (see instructions)		160.57	160.57	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		9,298	9,298	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		1,492,980	1,492,980	11.00
12.00	Program covered visits for mental health services (from contractor records)		0	57	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)		0	9,152	13.00
14.00	Limit adjustment for mental health services (see instructions)		0	9,152	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	2,995,112	16.00
16.01	Total program charges (see instructions)(from contractor's records)			2,603,326	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)			89,101	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)			102,511	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)			2,056,659	16.04
16.05	Total program cost (see instructions)		0	2,159,170	16.05
17.00	Primary payer amounts			243	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			321,777	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			438,414	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			2,158,927	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			114,907	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			2,273,834	22.00
23.00	Allowable bad debts (see instructions)			102,175	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			66,414	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			102,175	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25.50
25.99	Demonstration payment adjustment amount before sequestration			0	25.99
26.00	Net reimbursable amount (see instructions)			2,340,248	26.00
26.01	Sequestration adjustment (see instructions)			39,082	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			1,855,907	27.00
28.00	Tentative settlement (for contractor use only)			0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)			445,259	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II chapter I, §115.2			0	30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN:14-0059 Component CCN:14-8538	Period: From 07/01/2019 To 06/30/2020	Worksheet M-4 Date/Time Prepared: 2/1/2021 2:11 pm	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		4,764,974	4,764,974	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		0.001408	0.006511	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		6,709	31,025	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		51,430	24,724	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		58,139	55,749	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)		5,176,886	5,176,886	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		5,549,996	5,549,996	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		0.011230	0.010769	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		62,326	59,768	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		120,465	115,517	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)		336	1,554	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		358.53	74.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		188	639	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		67,404	47,503	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)			235,982	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)			114,907	16.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN:14-0059	Period: From 07/01/2019 To 06/30/2020	Worksheet M-5	
		Component CCN:14-8538		Date/Time Prepared: 2/1/2021 2:11 pm	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,801,606	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00	
Program to Provider					
3.01		02/12/2020	54,301	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3.05			0	3.05	
Provider to Program					
3.50			0	3.50	
3.51			0	3.51	
3.52			0	3.52	
3.53			0	3.53	
3.54			0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		54,301	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,855,907	4.00	
TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00	
Program to Provider					
5.01			0	5.01	
5.02			0	5.02	
5.03			0	5.03	
Provider to Program					
5.50			0	5.50	
5.51			0	5.51	
5.52			0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00	
6.01	SETTLEMENT TO PROVIDER		445,259	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		2,301,166	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	2.00		
8.00	Name of Contractor				8.00