

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
FORM APPROVED
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 11/30/2021 11:47 am
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PART I - COST REPORT STATUS

Provider use only 1. ☒ Electronically prepared cost report Date:11/30/2021 Time:11:47 am
 2. ☐ Manually prepared cost report
 3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report
 4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.
 Contractor use only 5. ☐ Cost Report Status 6. Date Received:
 (1) As Submitted 7. Contractor No. 10. NPR Date:
 (2) Settled without Audit 8. ☐ Initial Report for this Provider CCN 11. Contractor's Vendor Code: 4
 (3) Settled with Audit 9. ☐ Final Report for this Provider CCN 12. ☐ If line 5, column 1 is 4: Enter
 (4) Reopened number of times reopened = 0-9.
 (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 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed) MICHELLE HOPPER
Officer or Administrator of Provider(s)

VP FINANCE
Title

(Dated when report is electronically signed.)
Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-68,521	-22,767	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		365,626		0	10.00
200.00	Total	0	-68,521	342,859	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:47 am	
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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	3.00
4.00	Subprovider - IPF										4.00
5.00	Subprovider - IRF										5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF		JERSEY COMMUNITY HOSPITAL	14U059	41180		08/27/1993	N	P	N	7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		JCH MEDICAL GROUP JERSEYVILLE	148538	41180		01/01/2015	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00	Renal Dialysis										18.00
19.00	Other										19.00
							From:	To:			
							1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020	06/30/2021		20.00	
21.00	Type of Control (see instructions)						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	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.									22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 11:47 am

	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
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural Status	Date of Geographic Reclassification	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					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.					07/01/2020	06/30/2021	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)					With	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					With	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					or "N"		
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN:14-0059		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:47 am	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N					60.00
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00		62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0059

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From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
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11/30/2021 11:47 am

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

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 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:47 am	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N			80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N			81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N			85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N			87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		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		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		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.	N		Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		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

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 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:47 am	
			V	XIX	
			1.00	2.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR N Section §412.113(c). Enter "Y" for yes or "N" for no.				108.00
			Physical	Occupational	
			1.00	2.00	
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
				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	
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
<u>Miscellaneous Cost Reporting Information</u>					
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:		456,490	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N	118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N	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
<u>Transplant Center Information</u>					
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

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 07/01/2020 To 06/30/2021	
				Worksheet S-2 Part I Date/Time Prepared: 11/30/2021 11:47 am	
		1.00		2.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	Removed and reserved			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			140.00	
		1.00		2.00	
		2.00		3.00	
		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	
		1.00		2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			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	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N	
		Part A		Part B	
		1.00		2.00	
		2.00		3.00	
		3.00		4.00	
		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	
156.00	Subprovider - IPF	N		N	
157.00	Subprovider - IRF	N		N	
158.00	SUBPROVIDER	N		N	
159.00	SNF	N		N	
160.00	HOME HEALTH AGENCY	N		N	
161.00	CMHC	N		N	
				1.00	
Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			Enter N	
		Name		County	
		0		1.00	
		2.00		3.00	
		3.00		4.00	
		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)			0.00	
				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	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99	
				169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/30/2021 11:47 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)			171.00

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 07/01/2020 To 06/30/2021	
		Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 11:47 am			
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	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	10/28/2021	Y	10/28/2021
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 07/01/2020 To 06/30/2021	
		Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 11:47 am			
		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N	N		20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N		21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N			22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N			23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N			24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N			25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N			26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N			27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				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

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 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/30/2021 11:47 am	
		3.00			
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR			41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 11:47 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	42	15,330	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	15,330	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	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	16,790	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 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 11:47 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,130	14	2,164			1.00
2.00	HMO and other (see instructions)	436	122				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	27	0	72			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)	1,157	14	2,236			7.00
8.00	INTENSIVE CARE UNIT	187	12	348			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)	1,344	26	2,584	0.00	255.69	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	16,509	16,863	71,715	0.00	99.46	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	355.15	27.00
28.00	Observation Bed Days		10	876			28.00
29.00	Ambulance Trips	1,071					29.00
30.00	Employee discount days (see instruction)			11			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 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/30/2021 11:47 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	424	6	725	1.00
2.00 HMO and other (see instructions)			131	44		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	424	6	725	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 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/30/2021 11:47 am

	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	23,867,835	0	23,867,835	738,720.00	32.31
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		2,815,373	0	2,815,373	25,190.00	111.77
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		4,223,780	-159,333	4,064,447	176,039.00	23.09
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)		1,231,043	159,333	1,390,376	60,338.00	23.04
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,090,389	0	1,090,389	20,466.00	53.28
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		2,095	0	2,095	25.00	83.80
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)		4,201,072	0	4,201,072		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		474,701	0	474,701		
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		303,863	0	303,863		
24.00	Wage-related costs (RHC/FQHC)		1,386,029	0	1,386,029		
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 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/30/2021 11:47 am

		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	189,380	0	189,380	6,275.00	30.18	26.00
27.00	Administrative & General	5.00	2,880,345	0	2,880,345	90,040.00	31.99	27.00
28.00	Administrative & General under contract (see inst.)		287,287	0	287,287	10,795.00	26.61	28.00
29.00	Maintenance & Repairs	6.00	266,975	0	266,975	8,982.00	29.72	29.00
30.00	Operation of Plant	7.00	63,191	0	63,191	3,170.00	19.93	30.00
31.00	Laundry & Linen Service	8.00	31,992	0	31,992	2,105.00	15.20	31.00
32.00	Housekeeping	9.00	215,341	0	215,341	17,104.00	12.59	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	328,560	0	328,560	22,423.00	14.65	34.00
35.00	Dietary under contract (see instructions)		33,493	0	33,493	782.00	42.83	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	493,517	0	493,517	11,938.00	41.34	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	259,137	0	259,137	12,825.00	20.21	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 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/30/2021 11:47 am

	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)	17,149,462	159,333	17,308,795	549,068.00	31.52	1.00
2.00	Excluded area salaries (see instructions)	1,231,043	159,333	1,390,376	60,338.00	23.04	2.00
3.00	Subtotal salaries (line 1 minus line 2)	15,918,419	0	15,918,419	488,730.00	32.57	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,092,484	0	1,092,484	20,491.00	53.32	4.00
5.00	Subtotal wage-related costs (see inst.)	4,201,072	0	4,201,072	0.00	26.39	5.00
6.00	Total (sum of lines 3 thru 5)	21,211,975	0	21,211,975	509,221.00	41.66	6.00
7.00	Total overhead cost (see instructions)	5,049,218	0	5,049,218	186,439.00	27.08	7.00

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST	In Lieu of Form CMS-2552-10	
HOSPITAL WAGE RELATED COSTS		Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2021 11:47 am
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		663,497	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)		3,892,181	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)		37,588	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)		7,937	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		192,289	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		1,545,221	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		26,952	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		6,365,665	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 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/30/2021 11:47 am

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	1,090,389	6,365,665	1.00
2.00	Hospital	1,090,389	4,675,773	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	1,689,892	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 07/01/2020 To 06/30/2021 Worksheet S-8 Date/Time Prepared: 11/30/2021 11:47 am	
		RHC I		Cost	
		1.00			
Clinic Address and Identification					
1.00	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.)			0	10.00
		Sunday		Monday	Tuesday
		from	to	from	to
		1.00	2.00	3.00	4.00
Facility hours of operations (1)					
11.00	CLINIC	08:00		17:00	08:00
		1.00		2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N	12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			7	13.00
		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 JERSEYVILLE		148538	14.01
14.02		JCH MEDICAL GROUP HARDIN		148539	14.02
14.03		JCH MEDICAL GROUP ROODHOUSE		148540	14.03
14.04		JCH MEDICAL GROUP JERSEYVILLE		148550	14.04
14.05		JCH MEDICAL GROUP JERSEYVILLE		148604	14.05
14.06		JCH MEDICAL GROUP JERSEYVILLE		148610	14.06
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
				Total Visits	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00

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 07/01/2020 To 06/30/2021	Worksheet S-8 Date/Time Prepared: 11/30/2021 11:47 am
				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
		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 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/30/2021 11:47 am	
			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.361630		1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid	2,737,484		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	2,356,504		5.00	
6.00	Medicaid charges	17,391,891		6.00	
7.00	Medicaid cost (line 1 times line 6)	6,289,430		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)	1,195,442		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, 15, 17, 18 and 16)	1,195,442		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)	113,449	64,759	178,208	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	41,027	64,759	105,786	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)	41,027	64,759	105,786	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)	1,908,018		26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	221,558		27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	340,858		27.01	
28.00	Non-Medicare bad debt expense (see instructions)	1,567,160		28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	686,032		29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	791,818		30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,987,260		31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0059

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

Worksheet A

Date/Time Prepared:
11/30/2021 11:47 am

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		1,026,477	1,026,477	144,092	1,170,569	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,014,147	1,014,147	123,105	1,137,252	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	189,380	4,770,377	4,959,757	192,289	5,152,046	4.00
5.01	00590	BUSINESS OFFICE - BILLING	362,188	709,209	1,071,397	0	1,071,397	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	2,518,157	2,161,752	4,679,909	-197,646	4,482,263	5.02
6.00	00600	MAINTENANCE & REPAIRS	266,975	362,995	629,970	0	629,970	6.00
7.00	00700	OPERATION OF PLANT	63,191	1,163,021	1,226,212	0	1,226,212	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,992	40,377	72,369	0	72,369	8.00
9.00	00900	HOUSEKEEPING	215,341	130,754	346,095	0	346,095	9.00
10.00	01000	DIETARY	328,560	252,642	581,202	0	581,202	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	493,517	60,973	554,490	0	554,490	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	748	748	0	748	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	259,137	274,145	533,282	-41,242	492,040	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	643,202	643,202	0	643,202	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,448,167	709,597	2,157,764	-2,095	2,155,669	30.00
31.00	03100	INTENSIVE CARE UNIT	590,714	74,774	665,488	0	665,488	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	506,122	523,794	1,029,916	-38,561	991,355	50.00
51.00	05100	RECOVERY ROOM	81,321	6,493	87,814	0	87,814	51.00
53.00	05300	ANESTHESIOLOGY	61,686	30,082	91,768	0	91,768	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,079,455	1,037,852	2,117,307	-170,795	1,946,512	54.00
60.00	06000	LABORATORY	1,030,287	1,181,017	2,211,304	0	2,211,304	60.00
66.00	06600	PHYSICAL THERAPY	0	1,090,020	1,090,020	0	1,090,020	66.00
69.00	06900	ELECTROCARDIOLOGY	326,632	101,982	428,614	-26,851	401,763	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	916,754	916,754	23,100	939,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,028,169	1,028,169	0	1,028,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	510,263	1,949,956	2,460,219	0	2,460,219	73.00
75.00	07500	ASC (NON-DISTINCT PART)	696,444	196,891	893,335	0	893,335	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	7,039,153	2,170,148	9,209,301	-263,286	8,946,015	88.00
90.00	09000	CLINIC	2,608,939	1,277,935	3,886,874	0	3,886,874	90.00
91.00	09100	EMERGENCY	1,929,171	1,253,713	3,182,884	-316	3,182,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	882,319	171,098	1,053,417	-94	1,053,323	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	34,372	34,372	0	34,372	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)	23,519,111	26,365,466	49,884,577	-258,300	49,626,277	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	51,745	164,299	216,044	258,300	474,344	192.00
192.01	19201	WELLNESS CENTER	296,979	141,810	438,789	0	438,789	192.01
192.03	19203	COMMUNITY RELATIONS	0	221,234	221,234	0	221,234	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	23,867,835	26,892,809	50,760,644	0	50,760,644	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN:14-0059

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

Worksheet A

Date/Time Prepared:
11/30/2021 11:47 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-76,837	1,093,732	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	1,137,252	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-933,075	4,218,971	4.00
5.01	00590	BUSINESS OFFICE - BILLING	0	1,071,397	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	-550,675	3,931,588	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	629,970	6.00
7.00	00700	OPERATION OF PLANT	0	1,226,212	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	72,369	8.00
9.00	00900	HOUSEKEEPING	0	346,095	9.00
10.00	01000	DIETARY	-145,995	435,207	10.00
11.00	01100	CAFETERIA	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	554,490	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	748	14.00
15.00	01500	PHARMACY	-110	-110	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,749	483,291	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-643,202	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-503,422	1,652,247	30.00
31.00	03100	INTENSIVE CARE UNIT	0	665,488	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	991,355	50.00
51.00	05100	RECOVERY ROOM	0	87,814	51.00
53.00	05300	ANESTHESIOLOGY	0	91,768	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-115,127	1,831,385	54.00
60.00	06000	LABORATORY	-14,400	2,196,904	60.00
66.00	06600	PHYSICAL THERAPY	0	1,090,020	66.00
69.00	06900	ELECTROCARDIOLOGY	-2,100	399,663	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	939,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,028,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,460,219	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	893,335	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-213,208	8,732,807	88.00
90.00	09000	CLINIC	-959,269	2,927,605	90.00
91.00	09100	EMERGENCY	-1,574,423	1,608,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-10,590	1,042,733	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	-100	34,272	97.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-5,751,282	43,874,995	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	474,344	192.00
192.01	19201	WELLNESS CENTER	-278	438,511	192.01
192.03	19203	COMMUNITY RELATIONS	0	221,234	192.03
200.00		TOTAL (SUM OF LINES 118 through 199)	-5,751,560	45,009,084	200.00

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - WORKERS COMPENSATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	192,289	1.00
	TOTALS		0	192,289	
B - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	628	1.00
	TOTALS		0	628	
C - RENTAL EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	143,693	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	122,876	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
	TOTALS		0	266,569	
E - MEDICAL GROUP ADMIN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	159,333	103,953	1.00
	TOTALS		159,333	103,953	
I - OR SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	23,100	1.00
	PATIENTS				
	TOTALS		0	23,100	
500.00	Grand Total: Increases		159,333	586,539	500.00

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
A - WORKERS COMPENSATION						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	192,289	0	1.00
	TOTALS		0	192,289		
B - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	628	12	1.00
	TOTALS		0	628		
C - RENTAL EXPENSE						
1.00	ADMINISTRATIVE AND GENERAL	5.02	0	4,729	10	1.00
2.00	MEDICAL RECORDS & LIBRARY	16.00	0	41,242	10	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,095	0	3.00
4.00	OPERATING ROOM	50.00	0	15,461	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	170,795	0	5.00
6.00	ELECTROCARDIOLOGY	69.00	0	26,851	0	6.00
7.00	EMERGENCY	91.00	0	316	0	7.00
8.00	AMBULANCE SERVICES	95.00	0	94	0	8.00
9.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4,986	0	9.00
	TOTALS		0	266,569		
E - MEDICAL GROUP ADMIN						
1.00	RURAL HEALTH CLINIC	88.00	159,333	103,953	0	1.00
	TOTALS		159,333	103,953		
I - OR SUPPLIES						
1.00	OPERATING ROOM	50.00	0	23,100	0	1.00
	TOTALS		0	23,100		
500.00	Grand Total: Decreases		159,333	586,539		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/30/2021 11:47 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	55,000	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,590,529	0	0	0	0	3.00
4.00	Building Improvements	7,384,010	452,085	0	452,085	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	13,895,277	1,883,324	0	1,883,324	3,235	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,924,816	2,335,409	0	2,335,409	3,235	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	40,924,816	2,335,409	0	2,335,409	3,235	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	19,590,529	0				3.00
4.00	Building Improvements	7,836,095	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	15,775,366	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	43,256,990	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	43,256,990	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/30/2021 11:47 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	824,121	0	202,356	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,014,147	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,838,268	0	202,356	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	1,026,477				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,014,147				2.00
3.00	Total (sum of lines 1-2)	0	2,040,624				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/30/2021 11:47 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	27,481,624	0	27,481,624	0.635311	399	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,775,366	0	15,775,366	0.364689	229	2.00
3.00	Total (sum of lines 1-2)	43,256,990	0	43,256,990	1.000000	628	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	399	819,639	143,693	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	229	1,014,147	122,876	2.00
3.00	Total (sum of lines 1-2)	0	0	628	1,833,786	266,569	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	130,001	399	0	0	1,093,732	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	229	0	0	1,137,252	2.00
3.00	Total (sum of lines 1-2)	130,001	628	0	0	2,230,984	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-0059

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 11:47 am

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	-72,355	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	-2,495	ADMINISTRATIVE AND GENERAL	5.02		0	7.00
8.00	Television and radio service (chapter 21)	A	-4,482	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	-3,168,741				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	-145,835	DIETARY	10.00		0	14.00
15.00	Rental of quarters to employees and others	B	-61,471	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	-110	PHARMACY	15.00		0	17.00
18.00	Sale of medical records and abstracts	B	-8,749	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	-160	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	-643,202	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	-239,732	ADMINISTRATIVE AND GENERAL	5.02		0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN:14-0059

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

Worksheet A-8

Date/Time Prepared:
11/30/2021 11:47 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7	Ref.
	1.00	2.00	3.00	4.00	5.00	
33.01 PHYSICIAN RECRUITMENT	A	-28,120	ADMINISTRATIVE AND GENERAL	5.02	0	33.01
33.02 MISC REV	B	-100	DURABLE MEDICAL EQUIP. - SOLD	97.00	0	33.02
33.03 LIFE LINE REVENUE	B	-24,846	ADMINISTRATIVE AND GENERAL	5.02	0	33.03
33.04 SELF INSURANCE CLAIMS	A	-818,370	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05 ADVERTISING	A	-70,656	ADMINISTRATIVE AND GENERAL	5.02	0	33.05
33.06 MARKETING SALARIES	A	-45,258	ADMINISTRATIVE AND GENERAL	5.02	0	33.06
33.07 MARKETING BENEFITS	A	-20,190	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08 LOBBYING EXPENSES	A	-13,421	ADMINISTRATIVE AND GENERAL	5.02	0	33.08
33.09 ADVERTISING	A	-278	WELLNESS CENTER	192.01	0	33.09
33.10 FOUNDATION SALARIES	A	-63,248	ADMINISTRATIVE AND GENERAL	5.02	0	33.10
33.11 FOUNDATION BENEFITS	A	-1,882	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12 NON-ALLOWABLE DUES	A	-1,327	ADMINISTRATIVE AND GENERAL	5.02	0	33.12
33.13 NP - HOSPITALIST	A	-213,208	RURAL HEALTH CLINIC	88.00	0	33.13
33.14 HOSPITALIST BENEFITS	A	-44,305	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15 EMS TRAINING REVENUE	B	-10,590	AMBULANCE SERVICES	95.00	0	33.15
33.16 ED PHYSICIAN BENEFITS	A	-48,328	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17 RECYCLING REVENUE - MISC	B	-101	ADMINISTRATIVE AND GENERAL	5.02	0	33.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5,751,560				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 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/30/2021 11:47 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	852,232	852,232	0	0	0	1.00
2.00	91.00	EMERGENCY	722,191	722,191	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	503,422	503,422	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	115,127	115,127	0	0	0	4.00
5.00	60.00	LABORATORY	14,400	14,400	0	0	0	5.00
6.00	90.00	CLINIC	959,269	959,269	0	0	0	6.00
7.00	69.00	ELECTROCARDIOLOGY	2,100	2,100	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			3,168,741	3,168,741	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	69.00	ELECTROCARDIOLOGY	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	852,232		1.00
2.00	91.00	EMERGENCY	0	0	0	722,191		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	503,422		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	115,127		4.00
5.00	60.00	LABORATORY	0	0	0	14,400		5.00
6.00	90.00	CLINIC	0	0	0	959,269		6.00
7.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,100		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	3,168,741		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN:14-0059

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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	1,093,732	1,093,732			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,137,252		1,137,252		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,218,971	1,850	0	4,220,821	4.00
5.01	00590	BUSINESS OFFICE - BILLING	1,071,397	6,392	572	64,562	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	3,931,588	135,810	325,474	448,877	5.02
6.00	00600	MAINTENANCE & REPAIRS	629,970	39,894	0	47,590	6.00
7.00	00700	OPERATION OF PLANT	1,226,212	0	0	11,264	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	72,369	3,911	3,234	5,703	8.00
9.00	00900	HOUSEKEEPING	346,095	2,453	5,773	38,386	9.00
10.00	01000	DIETARY	435,207	23,220	1,141	58,568	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	554,490	1,850	572	87,972	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	748	4,479	0	0	14.00
15.00	01500	PHARMACY	-110	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	483,291	7,506	49,204	46,193	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,652,247	39,796	25,571	258,144	30.00
31.00	03100	INTENSIVE CARE UNIT	665,488	14,803	4,497	105,298	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	991,355	28,911	76,810	90,219	50.00
51.00	05100	RECOVERY ROOM	87,814	2,740	0	14,496	51.00
53.00	05300	ANESTHESIOLOGY	91,768	4,381	846	10,996	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,831,385	45,235	304,407	192,419	54.00
60.00	06000	LABORATORY	2,196,904	20,816	35,745	183,655	60.00
66.00	06600	PHYSICAL THERAPY	1,090,020	22,092	943	0	66.00
69.00	06900	ELECTROCARDIOLOGY	399,663	20,697	40,600	58,224	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	939,854	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,028,169	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,460,219	7,745	47,547	90,957	73.00
75.00	07500	ASC (NON-DISTINCT PART)	893,335	24,804	9,022	124,145	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	8,732,807	228,248	64,981	1,226,365	88.00
90.00	09000	CLINIC	2,927,605	55,608	51,674	465,059	90.00
91.00	09100	EMERGENCY	1,608,145	46,321	5,935	343,886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,042,733	33,888	59,683	157,279	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	34,272	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)	43,874,995	823,450	1,114,231	4,130,257	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,582	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	474,344	87,358	6,958	37,626	192.00
192.01	19201	WELLNESS CENTER	438,511	178,711	16,063	52,938	192.01
192.03	19203	COMMUNITY RELATIONS	221,234	631	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)	45,009,084	1,093,732	1,137,252	4,220,821	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	4,841,749	4,841,749			5.02
6.00	00600	MAINTENANCE & REPAIRS	717,454	86,481	803,935		6.00
7.00	00700	OPERATION OF PLANT	1,237,476	149,164	0	1,386,640	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,217	10,272	3,456	5,961	8.00
9.00	00900	HOUSEKEEPING	392,707	47,337	2,168	3,739	9.00
10.00	01000	DIETARY	518,136	62,456	20,519	35,391	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	644,884	77,734	1,635	2,820	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,227	630	3,958	6,826	14.00
15.00	01500	PHARMACY	-110	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	586,194	70,659	6,633	11,441	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,002,794	241,415	35,166	60,655	30.00
31.00	03100	INTENSIVE CARE UNIT	795,982	95,947	13,080	22,561	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,241,083	149,599	25,548	44,065	50.00
51.00	05100	RECOVERY ROOM	108,623	13,093	2,422	4,177	51.00
53.00	05300	ANESTHESIOLOGY	136,735	16,482	3,871	6,677	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,679,680	323,006	39,972	68,944	54.00
60.00	06000	LABORATORY	2,633,908	317,489	18,394	31,727	60.00
66.00	06600	PHYSICAL THERAPY	1,166,474	140,606	19,521	33,671	66.00
69.00	06900	ELECTROCARDIOLOGY	554,387	66,825	18,289	31,545	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	957,678	115,438	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,041,023	125,484	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,665,734	321,325	6,844	11,804	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,080,875	130,288	21,918	37,805	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,371,310	1,250,150	201,692	347,883	88.00
90.00	09000	CLINIC	3,573,415	430,736	49,138	84,754	90.00
91.00	09100	EMERGENCY	2,103,157	253,512	40,932	70,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,313,615	158,342	29,945	51,649	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	35,721	4,306	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	43,491,128	4,658,776	565,101	974,695	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,582	432	3,165	5,459	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	606,286	73,081	77,194	133,145	192.00
192.01	19201	WELLNESS CENTER	686,223	82,717	157,918	272,380	192.01
192.03	19203	COMMUNITY RELATIONS	221,865	26,743	557	961	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)	45,009,084	4,841,749	803,935	1,386,640	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	445,951					9.00
10.00	01000	DIETARY	23,327	659,829				10.00
11.00	01100	CAFETERIA	0	532,825	532,825			11.00
13.00	01300	NURSING ADMINISTRATION	1,372	0	17,835	746,280		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,744	0	0	0	19,385	14.00
15.00	01500	PHARMACY	4,116	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,372	0	16,720	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	93,308	108,056	84,717	185,905	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,349	18,948	15,606	64,397	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	50,770	0	34,556	52,229	0	50.00
51.00	05100	RECOVERY ROOM	1,372	0	2,229	8,991	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	7,803	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,699	0	53,505	91	0	54.00
60.00	06000	LABORATORY	17,838	0	51,276	0	0	60.00
66.00	06600	PHYSICAL THERAPY	26,071	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	15,094	0	12,262	42,861	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	9,258	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,127	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	21,179	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	30,187	0	41,244	84,815	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	50,770	0	30,097	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	57,631	0	62,423	157,383	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	37,900	149,608	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)	413,020	659,829	489,352	746,280	19,385	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	2,744	0	32,326	0	0	192.00
192.01	19201	WELLNESS CENTER	30,187	0	11,147	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)	445,951	659,829	532,825	746,280	19,385	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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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	4,006				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	693,019			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	162,557	0	3,005,165	30.00
31.00	03100	INTENSIVE CARE UNIT	0	14,821	0	1,058,751	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	204,870	0	1,809,845	50.00
51.00	05100	RECOVERY ROOM	0	0	0	140,907	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	171,568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,160	0	3,222,926	54.00
60.00	06000	LABORATORY	0	19,762	0	3,090,394	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,386,343	66.00
69.00	06900	ELECTROCARDIOLOGY	0	35,938	0	778,076	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,082,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,176,634	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,006	0	0	3,030,892	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	1,439,960	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	12,252,408	88.00
90.00	09000	CLINIC	0	0	0	4,138,057	90.00
91.00	09100	EMERGENCY	0	107,654	0	2,874,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	127,257	0	1,868,316	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	40,027	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,006	693,019	0	42,566,736	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	12,638	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	929,822	192.00
192.01	19201	WELLNESS CENTER	0	0	0	1,249,762	192.01
192.03	19203	COMMUNITY RELATIONS	0	0	0	250,126	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)	4,006	693,019	0	45,009,084	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

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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	1,850	0	1,850	4.00
5.01	00590	BUSINESS OFFICE - BILLING	0	6,392	572	6,964	5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	0	135,810	325,474	461,284	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	39,894	0	39,894	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,911	3,234	7,145	8.00
9.00	00900	HOUSEKEEPING	0	2,453	5,773	8,226	9.00
10.00	01000	DIETARY	0	23,220	1,141	24,361	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,850	572	2,422	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,479	0	4,479	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,506	49,204	56,710	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	39,796	25,571	65,367	30.00
31.00	03100	INTENSIVE CARE UNIT	0	14,803	4,497	19,300	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	28,911	76,810	105,721	50.00
51.00	05100	RECOVERY ROOM	0	2,740	0	2,740	51.00
53.00	05300	ANESTHESIOLOGY	0	4,381	846	5,227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,235	304,407	349,642	54.00
60.00	06000	LABORATORY	0	20,816	35,745	56,561	60.00
66.00	06600	PHYSICAL THERAPY	0	22,092	943	23,035	66.00
69.00	06900	ELECTROCARDIOLOGY	0	20,697	40,600	61,297	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	7,745	47,547	55,292	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	24,804	9,022	33,826	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	228,248	64,981	293,229	88.00
90.00	09000	CLINIC	0	55,608	51,674	107,282	90.00
91.00	09100	EMERGENCY	0	46,321	5,935	52,256	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	33,888	59,683	93,571	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	823,450	1,114,231	1,937,681	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	3,582	0	3,582	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	87,358	6,958	94,316	192.00
192.01	19201	WELLNESS CENTER	0	178,711	16,063	194,774	192.01
192.03	19203	COMMUNITY RELATIONS	0	631	0	631	192.03
200.00		Cross Foot Adjustments				0	200.00
201.00		Negative Cost Centers		0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,093,732	1,137,252	2,230,984	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	6,992				5.01
5.02	00501	ADMINISTRATIVE AND GENERAL	0	461,480			5.02
6.00	00600	MAINTENANCE & REPAIRS	0	8,243	48,158		6.00
7.00	00700	OPERATION OF PLANT	0	14,217	0	14,222	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	979	207	61	8.00
9.00	00900	HOUSEKEEPING	0	4,512	130	38	9.00
10.00	01000	DIETARY	0	5,953	1,229	363	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,409	98	29	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	60	237	70	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,735	397	117	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	164	23,010	2,107	622	30.00
31.00	03100	INTENSIVE CARE UNIT	36	9,145	784	231	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	327	14,259	1,530	452	50.00
51.00	05100	RECOVERY ROOM	22	1,248	145	43	51.00
53.00	05300	ANESTHESIOLOGY	175	1,571	232	68	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,906	30,787	2,394	707	54.00
60.00	06000	LABORATORY	1,196	30,261	1,102	325	60.00
66.00	06600	PHYSICAL THERAPY	325	13,402	1,169	345	66.00
69.00	06900	ELECTROCARDIOLOGY	214	6,369	1,096	324	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	108	11,003	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78	11,960	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	360	30,627	410	121	73.00
75.00	07500	ASC (NON-DISTINCT PART)	180	12,418	1,313	388	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	723	119,152	12,081	3,569	88.00
90.00	09000	CLINIC	446	41,055	2,944	869	90.00
91.00	09100	EMERGENCY	601	24,163	2,452	724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	122	15,092	1,794	530	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	9	410	0	0	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,992	444,040	33,851	9,996	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	41	190	56	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,966	4,624	1,366	192.00
192.01	19201	WELLNESS CENTER	0	7,884	9,460	2,794	192.01
192.03	19203	COMMUNITY RELATIONS	0	2,549	33	10	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)	6,992	461,480	48,158	14,222	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	12,923					9.00
10.00	01000	DIETARY	676	32,608				10.00
11.00	01100	CAFETERIA	0	26,332	26,332			11.00
13.00	01300	NURSING ADMINISTRATION	40	0	881	10,917		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80	0	0	0	4,926	14.00
15.00	01500	PHARMACY	119	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	40	0	826	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	2,703	5,340	4,187	2,719	0	30.00
31.00	03100	INTENSIVE CARE UNIT	358	936	771	942	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,471	0	1,708	764	0	50.00
51.00	05100	RECOVERY ROOM	40	0	110	132	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	386	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	716	0	2,644	1	0	54.00
60.00	06000	LABORATORY	517	0	2,534	0	0	60.00
66.00	06600	PHYSICAL THERAPY	755	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	437	0	606	627	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2,352	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,574	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,047	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	875	0	2,038	1,241	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,471	0	1,487	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,670	0	3,085	2,302	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	1,873	2,189	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)	11,968	32,608	24,183	10,917	4,926	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	80	0	1,598	0	0	192.00
192.01	19201	WELLNESS CENTER	875	0	551	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)	12,923	32,608	26,332	10,917	4,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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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	116				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,845			16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0		19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	15,210		123,991	0 30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,387		34,341	0 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	19,170		146,011	0 50.00
51.00	05100	RECOVERY ROOM	0	0		4,486	0 51.00
53.00	05300	ANESTHESIOLOGY	0	0		7,664	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,886		391,797	0 54.00
60.00	06000	LABORATORY	0	1,849		94,425	0 60.00
66.00	06600	PHYSICAL THERAPY	0	0		39,031	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,363		74,428	0 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		13,463	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		14,612	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	116	0		88,013	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		53,359	0 75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0		432,296	0 88.00
90.00	09000	CLINIC	0	0		152,800	0 90.00
91.00	09100	EMERGENCY	0	10,073		99,140	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	11,907		127,147	0 95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0		419	0 97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	116	64,845	0	1,897,423	0 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		3,869	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		109,370	0 192.00
192.01	19201	WELLNESS CENTER	0	0		217,096	0 192.01
192.03	19203	COMMUNITY RELATIONS	0	0		3,223	0 192.03
200.00		Cross Foot Adjustments			0	0	0 200.00
201.00		Negative Cost Centers	3	0	0	3	0 201.00
202.00		TOTAL (sum lines 118 through 201)	119	64,845	0	2,230,984	0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN:14-0059

Period:
From 07/01/2020
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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	123,991
31.00	03100	INTENSIVE CARE UNIT	34,341
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	146,011
51.00	05100	RECOVERY ROOM	4,486
53.00	05300	ANESTHESIOLOGY	7,664
54.00	05400	RADIOLOGY-DIAGNOSTIC	391,797
60.00	06000	LABORATORY	94,425
66.00	06600	PHYSICAL THERAPY	39,031
69.00	06900	ELECTROCARDIOLOGY	74,428
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,463
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,612
73.00	07300	DRUGS CHARGED TO PATIENTS	88,013
75.00	07500	ASC (NON-DISTINCT PART)	53,359
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	432,296
90.00	09000	CLINIC	152,800
91.00	09100	EMERGENCY	99,140
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	
OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	127,147
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	419
SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,897,423
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,869
192.00	19200	PHYSICIANS' PRIVATE OFFICES	109,370
192.01	19201	WELLNESS CENTER	217,096
192.03	19203	COMMUNITY RELATIONS	3,223
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	3
202.00		TOTAL (sum lines 118 through 201)	2,230,984

COST ALLOCATION - STATISTICAL BASIS

Provider CCN:14-0059

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

Worksheet B-1

Date/Time Prepared:
11/30/2021 11:47 am

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	156,051					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,137,022				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	264	0	23,678,455			4.00
5.01	00590	BUSINESS OFFICE - BILLING	912	572	362,188	117,708,137		5.01
5.02	00591	ADMINISTRATIVE AND GENERAL	19,377	325,406	2,518,157	0	-4,841,749	5.02
6.00	00600	MAINTENANCE & REPAIRS	5,692	0	266,975	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	63,191	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	558	3,233	31,992	0	0	8.00
9.00	00900	HOUSEKEEPING	350	5,772	215,341	0	0	9.00
10.00	01000	DIETARY	3,313	1,141	328,560	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	264	572	493,517	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	110	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	49,194	259,137	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	25,566	1,448,167	2,784,296	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,112	4,496	590,714	607,203	0	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,125	76,794	506,122	5,539,413	0	50.00
51.00	05100	RECOVERY ROOM	391	0	81,321	367,946	0	51.00
53.00	05300	ANESTHESIOLOGY	625	846	61,686	2,960,229	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,454	304,346	1,079,455	31,540,693	0	54.00
60.00	06000	LABORATORY	2,970	35,738	1,030,287	20,266,509	0	60.00
66.00	06600	PHYSICAL THERAPY	3,152	943	0	5,501,410	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,953	40,592	326,632	3,625,403	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,835,583	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,323,806	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,105	47,537	510,263	6,103,577	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	3,539	9,020	696,444	3,045,243	0	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	32,566	64,968	6,879,820	12,246,002	0	88.00
90.00	09000	CLINIC	7,934	51,664	2,608,939	7,566,281	0	90.00
91.00	09100	EMERGENCY	6,609	5,934	1,929,171	10,182,305	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	4,835	59,671	882,319	2,063,049	0	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	0	0	149,189	0	97.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	117,488	1,114,005	23,170,398	117,708,137	-4,841,639	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	12,464	6,957	211,078	0	0	192.00
192.01	19201	WELLNESS CENTER	25,498	16,060	296,979	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)	1,093,732	1,137,252	4,220,821	1,142,923		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.008811	1.000202	0.178256	0.009710		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			1,850	6,992		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000078	0.000059		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 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/30/2021 11:47 am

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	40,167,445				5.02
6.00	00600	MAINTENANCE & REPAIRS	717,454	129,806			6.00
7.00	00700	OPERATION OF PLANT	1,237,476	0	129,806		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,217	558	558	7,671	8.00
9.00	00900	HOUSEKEEPING	392,707	350	350	0	325 9.00
10.00	01000	DIETARY	518,136	3,313	3,313	0	17 10.00
11.00	01100	CAFETERIA	0	0	0	0	0 11.00
13.00	01300	NURSING ADMINISTRATION	644,884	264	264	0	1 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,227	639	639	0	2 14.00
15.00	01500	PHARMACY	0	0	0	0	3 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	586,194	1,071	1,071	0	1 16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,002,794	5,678	5,678	2,237	68 30.00
31.00	03100	INTENSIVE CARE UNIT	795,982	2,112	2,112	370	9 31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,241,083	4,125	4,125	521	37 50.00
51.00	05100	RECOVERY ROOM	108,623	391	391	0	1 51.00
53.00	05300	ANESTHESIOLOGY	136,735	625	625	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,679,680	6,454	6,454	941	18 54.00
60.00	06000	LABORATORY	2,633,908	2,970	2,970	0	13 60.00
66.00	06600	PHYSICAL THERAPY	1,166,474	3,152	3,152	0	19 66.00
69.00	06900	ELECTROCARDIOLOGY	554,387	2,953	2,953	64	11 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	957,678	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,041,023	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,665,734	1,105	1,105	0	0 73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,080,875	3,539	3,539	938	22 75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	10,371,310	32,566	32,566	37	37 88.00
90.00	09000	CLINIC	3,573,415	7,934	7,934	1	0 90.00
91.00	09100	EMERGENCY	2,103,157	6,609	6,609	1,521	42 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,313,615	4,835	4,835	0	0 95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	35,721	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)	38,649,489	91,243	91,243	6,630	301 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,582	511	511	0	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	606,286	12,464	12,464	369	2 192.00
192.01	19201	WELLNESS CENTER	686,223	25,498	25,498	672	22 192.01
192.03	19203	COMMUNITY RELATIONS	221,865	90	90	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)	4,841,749	803,935	1,386,640	104,906	445,951 202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.120539	6.193358	10.682403	13.675662	1,372.156923 203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	461,480	48,158	14,222	8,394	12,923 204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.011489	0.371000	0.109564	1.094251	39.763077 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 07/01/2020
To 06/30/2021

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	48,753				10.00
11.00	01100	CAFETERIA	39,369	478			11.00
13.00	01300	NURSING ADMINISTRATION	0	16	197,624		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,968,023	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15	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	7,984	76	49,230	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,400	14	17,053	0	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	31	13,831	0	50.00
51.00	05100	RECOVERY ROOM	0	2	2,381	0	51.00
53.00	05300	ANESTHESIOLOGY	0	7	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	48	24	0	54.00
60.00	06000	LABORATORY	0	46	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	11	11,350	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	939,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,028,169	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	37	22,460	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	27	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	56	41,677	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	34	39,618	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)	48,753	439	197,624	1,968,023	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	29	0	0	192.00
192.01	19201	WELLNESS CENTER	0	10	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)	659,829	532,825	746,280	19,385	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.534121	1,114.696653	3.776262	0.009850	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	32,608	26,332	10,917	4,926	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.668841	55.087866	0.055241	0.002503	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 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
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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	8,697	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	2,040	30.00
31.00	03100	INTENSIVE CARE UNIT	186	31.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	2,571	50.00
51.00	05100	RECOVERY ROOM	0	51.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	253	54.00
60.00	06000	LABORATORY	248	60.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	451	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	1,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	1,597	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)	8,697	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)	693,019	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	79.684834	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,845	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.456019	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 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/30/2021 11:47 am
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		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	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	3,005,165		3,005,165	0	3,005,165	30.00
31.00	03100 INTENSIVE CARE UNIT	1,058,751		1,058,751	0	1,058,751	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,809,845		1,809,845	0	1,809,845	50.00
51.00	05100 RECOVERY ROOM	140,907		140,907	0	140,907	51.00
53.00	05300 ANESTHESIOLOGY	171,568		171,568	0	171,568	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,222,926		3,222,926	0	3,222,926	54.00
60.00	06000 LABORATORY	3,090,394		3,090,394	0	3,090,394	60.00
66.00	06600 PHYSICAL THERAPY	1,386,343	0	1,386,343	0	1,386,343	66.00
69.00	06900 ELECTROCARDIOLOGY	778,076		778,076	0	778,076	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,082,374		1,082,374	0	1,082,374	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,176,634		1,176,634	0	1,176,634	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,030,892		3,030,892	0	3,030,892	73.00
75.00	07500 ASC (NON-DISTINCT PART)	1,439,960		1,439,960	0	1,439,960	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	12,252,408		12,252,408	0	12,252,408	88.00
90.00	09000 CLINIC	4,138,057		4,138,057	0	4,138,057	90.00
91.00	09100 EMERGENCY	2,874,093		2,874,093	0	2,874,093	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	860,968		860,968		860,968	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	1,868,316		1,868,316	0	1,868,316	95.00
97.00	09700 DURABLE MEDICAL EQUIP. - SOLD	40,027		40,027	0	40,027	97.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	43,427,704	0	43,427,704	0	43,427,704	200.00
201.00	Less Observation Beds	860,968		860,968		860,968	201.00
202.00	Total (see instructions)	42,566,736	0	42,566,736	0	42,566,736	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
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					Title XVIII		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
			Inpatient	Outpatient	Total (col. 6 + col. 7)					
			6.00	7.00	8.00					
	INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	1,312,916		1,312,916				30.00	
31.00	03100	INTENSIVE CARE UNIT	607,203		607,203				31.00	
	ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	869,673	4,669,740	5,539,413	0.326721	0.000000		50.00	
51.00	05100	RECOVERY ROOM	61,671	306,275	367,946	0.382956	0.000000		51.00	
53.00	05300	ANESTHESIOLOGY	349,011	2,611,218	2,960,229	0.057958	0.000000		53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,603,468	29,937,225	31,540,693	0.102183	0.000000		54.00	
60.00	06000	LABORATORY	1,664,707	18,601,802	20,266,509	0.152488	0.000000		60.00	
66.00	06600	PHYSICAL THERAPY	589,646	4,911,764	5,501,410	0.251998	0.000000		66.00	
69.00	06900	ELECTROCARDIOLOGY	729,266	2,896,137	3,625,403	0.214618	0.000000		69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	646,597	1,188,986	1,835,583	0.589662	0.000000		71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	356,972	966,834	1,323,806	0.888827	0.000000		72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,596,461	4,507,116	6,103,577	0.496576	0.000000		73.00	
75.00	07500	ASC (NON-DISTINCT PART)	105,401	2,939,842	3,045,243	0.472856	0.000000		75.00	
	OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	12,246,002	12,246,002				88.00	
90.00	09000	CLINIC	0	7,566,281	7,566,281	0.546908	0.000000		90.00	
91.00	09100	EMERGENCY	1,496,083	8,686,222	10,182,305	0.282263	0.000000		91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	108,980	1,362,400	1,471,380	0.585143	0.000000		92.00	
	OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0	2,063,049	2,063,049	0.905609	0.000000		95.00	
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	149,189	149,189	0.268297	0.000000		97.00	
	SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE							113.00	
200.00		Subtotal (see instructions)	12,098,055	105,610,082	117,708,137				200.00	
201.00		Less Observation Beds							201.00	
202.00		Total (see instructions)	12,098,055	105,610,082	117,708,137				202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

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Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.326721			50.00
51.00	05100 RECOVERY ROOM	0.382956			51.00
53.00	05300 ANESTHESIOLOGY	0.057958			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.102183			54.00
60.00	06000 LABORATORY	0.152488			60.00
66.00	06600 PHYSICAL THERAPY	0.251998			66.00
69.00	06900 ELECTROCARDIOLOGY	0.214618			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.589662			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.888827			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.496576			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.472856			75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
90.00	09000 CLINIC	0.546908			90.00
91.00	09100 EMERGENCY	0.282263			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.585143			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0.905609			95.00
97.00	09700 DURABLE MEDICAL EQUIP. - SOLD	0.268297			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 07/01/2020
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				Title XIX	Hospital	Cost		
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,005,165		3,005,165	0	3,005,165	30.00
31.00	03100	INTENSIVE CARE UNIT	1,058,751		1,058,751	0	1,058,751	31.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,809,845		1,809,845	0	1,809,845	50.00
51.00	05100	RECOVERY ROOM	140,907		140,907	0	140,907	51.00
53.00	05300	ANESTHESIOLOGY	171,568		171,568	0	171,568	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,222,926		3,222,926	0	3,222,926	54.00
60.00	06000	LABORATORY	3,090,394		3,090,394	0	3,090,394	60.00
66.00	06600	PHYSICAL THERAPY	1,386,343	0	1,386,343	0	1,386,343	66.00
69.00	06900	ELECTROCARDIOLOGY	778,076		778,076	0	778,076	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,082,374		1,082,374	0	1,082,374	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,176,634		1,176,634	0	1,176,634	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,030,892		3,030,892	0	3,030,892	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,439,960		1,439,960	0	1,439,960	75.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	12,252,408		12,252,408	0	12,252,408	88.00
90.00	09000	CLINIC	4,138,057		4,138,057	0	4,138,057	90.00
91.00	09100	EMERGENCY	2,874,093		2,874,093	0	2,874,093	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	860,968		860,968	0	860,968	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,868,316		1,868,316	0	1,868,316	95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	40,027		40,027	0	40,027	97.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	43,427,704	0	43,427,704	0	43,427,704	200.00
201.00		Less Observation Beds	860,968		860,968		860,968	201.00
202.00		Total (see instructions)	42,566,736	0	42,566,736	0	42,566,736	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0059

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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	1,312,916		1,312,916			30.00	
31.00	03100	INTENSIVE CARE UNIT	607,203		607,203			31.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	869,673	4,669,740	5,539,413	0.326721	0.000000	50.00	
51.00	05100	RECOVERY ROOM	61,671	306,275	367,946	0.382956	0.000000	51.00	
53.00	05300	ANESTHESIOLOGY	349,011	2,611,218	2,960,229	0.057958	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,603,468	29,937,225	31,540,693	0.102183	0.000000	54.00	
60.00	06000	LABORATORY	1,664,707	18,601,802	20,266,509	0.152488	0.000000	60.00	
66.00	06600	PHYSICAL THERAPY	589,646	4,911,764	5,501,410	0.251998	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	729,266	2,896,137	3,625,403	0.214618	0.000000	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	646,597	1,188,986	1,835,583	0.589662	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	356,972	966,834	1,323,806	0.888827	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	1,596,461	4,507,116	6,103,577	0.496576	0.000000	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	105,401	2,939,842	3,045,243	0.472856	0.000000	75.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	12,246,002	12,246,002	1.000523	0.000000	88.00	
90.00	09000	CLINIC	0	7,566,281	7,566,281	0.546908	0.000000	90.00	
91.00	09100	EMERGENCY	1,496,083	8,686,222	10,182,305	0.282263	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	108,980	1,362,400	1,471,380	0.585143	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,063,049	2,063,049	0.905609	0.000000	95.00	
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0	149,189	149,189	0.268297	0.000000	97.00	
	SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00	
200.00		Subtotal (see instructions)	12,098,055	105,610,082	117,708,137			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	12,098,055	105,610,082	117,708,137			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN:14-0059

Period:
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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 07/01/2020
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			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	123,991	715	123,276	3,040	40.55	30.00	
31.00	INTENSIVE CARE UNIT	34,341		34,341	348	98.68	31.00	
200.00	Total (lines 30 through 199)	158,332		157,617	3,388		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	1,130	45,822					30.00
31.00	INTENSIVE CARE UNIT	187	18,453					31.00
200.00	Total (lines 30 through 199)	1,317	64,275					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/30/2021 11:47 am
Title XVIII				Hospital		PPS
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	146,011	5,539,413	0.026359	588,650	15,516	50.00
51.00 05100 RECOVERY ROOM	4,486	367,946	0.012192	29,522	360	51.00
53.00 05300 ANESTHESIOLOGY	7,664	2,960,229	0.002589	136,467	353	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	391,797	31,540,693	0.012422	1,597,741	19,847	54.00
60.00 06000 LABORATORY	94,425	20,266,509	0.004659	1,602,844	7,468	60.00
66.00 06600 PHYSICAL THERAPY	39,031	5,501,410	0.007095	353,823	2,510	66.00
69.00 06900 ELECTROCARDIOLOGY	74,428	3,625,403	0.020530	386,058	7,926	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13,463	1,835,583	0.007334	142,938	1,048	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	14,612	1,323,806	0.011038	182,615	2,016	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	88,013	6,103,577	0.014420	999,120	14,407	73.00
75.00 07500 ASC (NON-DISTINCT PART)	53,359	3,045,243	0.017522	32,598	571	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	432,296	12,246,002	0.035301	0	0	88.00
90.00 09000 CLINIC	152,800	7,566,281	0.020195	0	0	90.00
91.00 09100 EMERGENCY	99,140	10,182,305	0.009736	868,064	8,451	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	35,523	1,471,380	0.024143	51,662	1,247	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
97.00 09700 DURABLE MEDICAL EQUIP. - SOLD	419	149,189	0.002809	0	0	97.00
200.00 Total (lines 50 through 199)	1,647,467	113,724,969		6,972,102	81,720	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0059		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/30/2021 11:47 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
				1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00
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	3,040	0.00	1,130	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	348	0.00	187	31.00	
200.00		Total (lines 30 through 199)	0	0	3,388		1,317	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 07/01/2020
To 06/30/2021

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Part IV
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Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	Allied Health Post-Stepdown Adjustments	
		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 Provider CCN:14-0059 Period: From 07/01/2020 To 06/30/2021 Worksheet D Part IV Date/Time Prepared: 11/30/2021 11:47 am
THROUGH COSTS

				Title XVIII		Hospital	PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,539,413	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	367,946	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2,960,229	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	31,540,693	0.000000	54.00
60.00	06000	LABORATORY	0	0	0	20,266,509	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,501,410	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3,625,403	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,835,583	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,323,806	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,103,577	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	3,045,243	0.000000	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	12,246,002	0.000000	88.00
90.00	09000	CLINIC	0	0	0	7,566,281	0.000000	90.00
91.00	09100	EMERGENCY	0	0	0	10,182,305	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	1,471,380	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	149,189	0.000000	97.00
200.00		Total (lines 50 through 199)	0	0	0	113,724,969		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/30/2021 11:47 am

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	588,650	0	1,501,707	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	29,522	0	83,202	0	51.00
53.00	05300 ANESTHESIOLOGY	0.000000	136,467	0	355,503	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	1,597,741	0	10,621,887	0	54.00
60.00	06000 LABORATORY	0.000000	1,602,844	0	2,421,927	0	60.00
66.00	06600 PHYSICAL THERAPY	0.000000	353,823	0	34,974	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	386,058	0	848,817	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	142,938	0	178,421	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	182,615	0	262,099	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	999,120	0	2,122,026	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	32,598	0	1,970,438	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	5,251	0	90.00
91.00	09100 EMERGENCY	0.000000	868,064	0	2,633,801	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	51,662	0	592,647	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)		6,972,102	0	23,632,700	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part V Date/Time Prepared: 11/30/2021 11:47 am
			Title XVIII	Hospital	PPS
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.326721	1,501,707	0	0	490,639
51.00 05100 RECOVERY ROOM	0.382956	83,202	0	0	31,863
53.00 05300 ANESTHESIOLOGY	0.057958	355,503	0	0	20,604
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.102183	10,621,887	0	1,939	1,085,376
60.00 06000 LABORATORY	0.152488	2,421,927	5,453	0	369,315
66.00 06600 PHYSICAL THERAPY	0.251998	34,974	0	0	8,813
69.00 06900 ELECTROCARDIOLOGY	0.214618	848,817	0	0	182,171
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.589662	178,421	0	0	105,208
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.888827	262,099	0	0	232,961
73.00 07300 DRUGS CHARGED TO PATIENTS	0.496576	2,122,026	0	21,625	1,053,747
75.00 07500 ASC (NON-DISTINCT PART)	0.472856	1,970,438	0	0	931,733
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					
90.00 09000 CLINIC	0.546908	5,251	0	0	2,872
91.00 09100 EMERGENCY	0.282263	2,633,801	0	0	743,425
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.585143	592,647	0	0	346,783
OTHER REIMBURSABLE COST CENTERS					
95.00 09500 AMBULANCE SERVICES	0.905609		0		
97.00 09700 DURABLE MEDICAL EQUIP. - SOLD	0.268297	0	0	0	0
200.00 Subtotal (see instructions)		23,632,700	5,453	23,564	5,605,510
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00 Net Charges (line 200 - line 201)		23,632,700	5,453	23,564	5,605,510

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
11/30/2021 11:47 am

				Title XVIII	Hospital	PPS
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	198		54.00
60.00	06000	LABORATORY	832	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	10,738		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)	832	10,936		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	832	10,936		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0059

Period:

Worksheet D

Component CCN:14-U059

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/30/2021 11:47 am

			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	0.326721	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.382956	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.057958	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102183	0	0	0	54.00
60.00	06000	LABORATORY	0.152488	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.251998	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.214618	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.589662	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.888827	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.496576	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.472856	0	0	0	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC					88.00
90.00	09000	CLINIC	0.546908	0	0	0	90.00
91.00	09100	EMERGENCY	0.282263	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.585143	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.905609		0		95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0.268297	0	0	0	97.00
200.00		Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN:14-0059

Period:

Worksheet D

Component CCN:14-U059

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
11/30/2021 11:47 am

				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.)				
	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	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 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 11:47 am	
		Title XVIII	Hospital	PPS	
Cost Center Description				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,112	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			3,040	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)			2,164	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			36	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)			36	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)			1,130	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)			14	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)			13	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			237.99	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			243.34	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			169.71	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			169.71	20.00
21.00	Total general inpatient routine service cost (see instructions)			3,005,165	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)			8,568	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)			8,760	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)			17,328	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,987,837	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 22,987,837 minus line 36)			2,987,837	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)			982.84	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,110,609	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)			1,110,609	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 11:47 am
			Title XVIII	Hospital	PPS
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)
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	1,058,751	348	3,042.39	187	568,927
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,824,636
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,504,172
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					64,275
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					81,720
52.00 Total Program excludable cost (sum of lines 50 and 51)					145,995
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					3,358,177
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
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)					3,332
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					3,163
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					6,495
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					876
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					982.84
89.00 Observation bed cost (line 87 x line 88) (see instructions)					860,968

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/30/2021 11:47 am	
			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	123,991	3,005,165	0.041259	860,968	35,523	90.00
91.00 Nursing School cost	0	3,005,165	0.000000	860,968	0	91.00
92.00 Allied health cost	0	3,005,165	0.000000	860,968	0	92.00
93.00 All other Medical Education	0	3,005,165	0.000000	860,968	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/30/2021 11:47 am	
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		734,503	30.00
31.00	03100	INTENSIVE CARE UNIT		259,777	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.326721	588,650	192,324 50.00
51.00	05100	RECOVERY ROOM	0.382956	29,522	11,306 51.00
53.00	05300	ANESTHESIOLOGY	0.057958	136,467	7,909 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102183	1,597,741	163,262 54.00
60.00	06000	LABORATORY	0.152488	1,602,844	244,414 60.00
66.00	06600	PHYSICAL THERAPY	0.251998	353,823	89,163 66.00
69.00	06900	ELECTROCARDIOLOGY	0.214618	386,058	82,855 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.589662	142,938	84,285 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.888827	182,615	162,313 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.496576	999,120	496,139 73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.472856	32,598	15,414 75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000	CLINIC	0.546908	0	0 90.00
91.00	09100	EMERGENCY	0.282263	868,064	245,022 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.585143	51,662	30,230 92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			0 95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0.268297	0	0 97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		6,972,102	1,824,636 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net charges (line 200 minus line 201)		6,972,102	1,824,636 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN:14-0059

Period:

Worksheet D-3

Component CCN:14-U059

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

11/30/2021 11:47 am

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			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.326721	0	50.00
51.00	05100	RECOVERY ROOM	0.382956	0	51.00
53.00	05300	ANESTHESIOLOGY	0.057958	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.102183	0	54.00
60.00	06000	LABORATORY	0.152488	426	60.00
66.00	06600	PHYSICAL THERAPY	0.251998	19,890	66.00
69.00	06900	ELECTROCARDIOLOGY	0.214618	782	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.589662	1,099	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.888827	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.496576	3,120	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.472856	0	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.546908	0	90.00
91.00	09100	EMERGENCY	0.282263	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.585143	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
97.00	09700	DURABLE MEDICAL EQUIP. - SOLD	0.268297	0	97.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		25,317	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)		25,317	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 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 11:47 am	
		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)	737,681		1.01	
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	213,042		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)	17,965		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)	43.40		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	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 11:47 am	
		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		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		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		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			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		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			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)	2,968,688			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	546,529			48.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			3,402,069	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			218,470	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			14,903	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			3,635,442	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			3,635,442	61.00
62.00	Deductibles billed to program beneficiaries			449,708	62.00
63.00	Coinsurance billed to program beneficiaries			0	63.00
64.00	Allowable bad debts (see instructions)			112,547	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			73,156	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			95,036	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			3,258,890	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			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)			733	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-510	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			4,991	70.93
70.94	HRR adjustment amount (see instructions)			-3,386	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/30/2021 11:47 am
		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)	2020	366,170	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)	2021	456,420	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)		4,083,308	71.00
71.01	Sequestration adjustment (see instructions)		0	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		4,151,829	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)		-68,521	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)	109,236	324,145	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	1.0019690250	1.0015984595	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	215	518	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.9977	0.9992	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-251	-259	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 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2021 11:47 am

				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	737,681	0	737,681		737,681	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,213,042	0		2,213,042	2,213,042	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	17,965	0		17,965	17,965	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	2,968,688	0	737,681	2,231,007	2,968,688	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	3,546,529	0	1,985,610	1,560,919	3,546,529	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,402,069	0	1,673,628	1,728,441	3,402,069	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	218,470	0	0	218,470	218,470	16.00
17.00	Special add-on payments for new technologies	54.00	14,903	0	0	14,903	14,903	17.00
17.01	Net organ acquisition cost							17.01

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/30/2021 11:47 am

				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	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,673,628	1,961,814	3,635,442	19.00
		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	218,470	0	0	218,470	218,470	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	218,470	0	0	218,470	218,470	26.00
		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				0.218788	0.232652		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			366,170		366,170	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				456,420	456,420	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2021 11:47 am

		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	737,681	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,213,042		2,950,723	2,950,723	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	17,965		17,965	17,965	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	2,968,688	0	2,968,688	2,968,688	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	3,546,529	1,985,610	1,560,919	3,546,529	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	3,402,069	1,489,208	1,912,861	3,402,069	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	218,470	0	218,470	218,470	16.00
17.00	Special add-on payments for new technologies	54.00	14,903	0	14,903	14,903	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			1,489,208	2,146,234	3,635,442	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN:14-0059

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
11/30/2021 11:47 am

		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	218,470	0	218,470	218,470	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	218,470	0	218,470	218,470	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	366,170	366,170		366,170	28.00
29.00	Low volume adjustment on or after October 1	70.97	456,420		456,420	456,420	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	4,991	0	4,991	4,991	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	733	215	518	733	30.01
31.00	HRR adjustment (see instructions)	70.94	-3,386	0	-3,386	-3,386	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	-510	-251	-259	-510	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 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/30/2021 11:47 am	
		Title XVIII	Hospital	PPS	
			1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)	11,768		1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)	5,605,510		2.00	
3.00	OPPS payments	5,281,268		3.00	
4.00	Outlier payment (see instructions)	7,875		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)	11,768		11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges	29,017		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)	29,017		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)	29,017		18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	17,249		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)	11,768		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)	5,289,143		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)	1,016,417		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)	4,284,494		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)	4,284,494		30.00	
31.00	Primary payer payments	706		31.00	
32.00	Subtotal (line 30 minus line 31)	4,283,788		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)	140,839		34.00	
35.00	Adjusted reimbursable bad debts (see instructions)	91,545		35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	102,890		36.00	
37.00	Subtotal (see instructions)	4,375,333		37.00	
38.00	MSP-LCC reconciliation amount from PS&R	143		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)	4,375,190		40.00	
40.01	Sequestration adjustment (see instructions)	0		40.01	
40.02	Demonstration payment adjustment amount after sequestration	0		40.02	
40.03	Sequestration adjustment-PARHM pass-throughs	0		40.03	
41.00	Interim payments	4,397,957		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)	-22,767		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 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/30/2021 11:47 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		4,151,829		4,397,957	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)		4,151,829		4,397,957	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		68,521		22,767	6.02	
7.00	Total Medicare program liability (see instructions)		4,083,308		4,375,190	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 07/01/2020
To 06/30/2021Part I
Date/Time Prepared:
11/30/2021 11:47 am

		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		15,442		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)		15,442		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		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		15,442		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/30/2021 11:47 am	
		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

Health Financial Systems		JERSEY COMMUNITY HOSPITAL DIST		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet E-2	
		Component CCN:14-U059		Date/Time Prepared: 11/30/2021 11:47 am	
		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)		15,442	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-3, col. 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		27	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)		15,442	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		15,442	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)		15,442	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		15,442	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)		15,442	0	19.00
19.01	Sequestration adjustment (see instructions)		0	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		15,442	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)		0	0	22.00
22.01	Balance due provider/program-PARHM (see instructions)				22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	23.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))				201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))				202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
Comparision of PPS versus Cost Reimbursement					
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)				215.00

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

Provider CCN:14-0059

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

Worksheet G

Date/Time Prepared:
11/30/2021 11:47 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	13,565,202	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	20,474,191	0	0	0	4.00
5.00	Other receivable	222,389	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,101,382	0	0	0	6.00
7.00	Inventory	840,579	0	0	0	7.00
8.00	Prepaid expenses	514,964	0	0	0	8.00
9.00	Other current assets	282,791	0	0	0	9.00
10.00	Due from other funds	5,338,798	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	27,137,532	0	0	0	11.00
FIXED ASSETS						
12.00	Land	55,000	0	0	0	12.00
13.00	Land improvements	522,220	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	22,752,660	0	0	0	15.00
16.00	Accumulated depreciation	-13,062,854	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	20,449,330	0	0	0	23.00
24.00	Accumulated depreciation	-16,400,083	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)	14,316,273	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	22,929	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,929	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	41,476,734	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,430,552	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,640,360	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	4,111,915	0	0	0	40.00
41.00	Deferred income	798,165	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	90,909	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	9,071,901	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,032,199	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,553,163	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	5,585,362	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	14,657,263	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	26,819,471	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)	26,819,471	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	41,476,734	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN:14-0059

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

Worksheet G-1

Date/Time Prepared:
11/30/2021 11:47 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		16,184,129		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		10,635,342				2.00
3.00	Total (sum of line 1 and line 2)		26,819,471		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)		26,819,471		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)		26,819,471		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 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/30/2021 11:47 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	4,239,236		4,239,236	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)	4,239,236		4,239,236	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	677,861		677,861	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)	677,861		677,861	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,917,097		4,917,097	17.00
18.00	Ancillary services	8,967,524	77,953,551	86,921,075	18.00
19.00	Outpatient services	1,816,688	19,105,829	20,922,517	19.00
20.00	RURAL HEALTH CLINIC	0	11,679,574	11,679,574	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,216,454	2,216,454	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	452,269	452,269	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. line 1)	6,315,701,309	111,407,677	127,108,986	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		50,760,644		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)		50,760,644		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet G-3 Date/Time Prepared: 11/30/2021 11:47 am
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		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	127,108,986	1.00
2.00	Less contractual allowances and discounts on patients' accounts	80,323,603	2.00
3.00	Net patient revenues (line 1 minus line 2)	46,785,383	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	50,760,644	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,975,261	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	91,340	6.00
7.00	Income from investments	72,355	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	6,161	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	145,801	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	584,357	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	305,757	24.00
24.01	PROPERTY TAX AND REPLACEMENT TAXES	404,442	24.01
24.02	GRANT REVENUE	5,252,223	24.02
24.03	GAIN ON SALES OF ASSETS	0	24.03
24.04	POPULATION HEALTH	192,636	24.04
24.50	COVID-19 PHE Funding	7,555,525	24.50
25.00	Total other income (sum of lines 6-24)	14,610,597	25.00
26.00	Total (line 5 plus line 25)	10,635,336	26.00
27.00	ROUNDING	-6	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-6	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	10,635,342	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/30/2021 11:47 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		218,470	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)		6.91	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)		218,470	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 Component CCN:14-8538		Period: From 07/01/2020 To 06/30/2021		Worksheet M-1 Date/Time Prepared: 11/30/2021 11:47 am	
				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	2,372,834	0	2,372,834	-13,082	2,359,752	1.00		
2.00	Physician Assistant	364,431	0	364,431	0	364,431	2.00		
3.00	Nurse Practitioner	1,410,687	0	1,410,687	0	1,410,687	3.00		
4.00	Visiting Nurse	0	0	0	0	0	4.00		
5.00	Other Nurse	75,053	0	75,053	0	75,053	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	1,508,934	0	1,508,934	0	1,508,934	9.00		
10.00	Subtotal (sum of lines 1 through 9)	5,731,939	0	5,731,939	-13,082	5,718,857	10.00		
11.00	Physician Services Under Agreement	0	3,680	3,680	0	3,680	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	3,680	3,680	0	3,680	14.00		
15.00	Medical Supplies	0	626,913	626,913	-2,439	624,474	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	626,913	626,913	-2,439	624,474	21.00		
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,731,939	630,593	6,362,532	-15,521	6,347,011	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	13,291	0	13,291	0	13,291	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)	13,291	0	13,291	0	13,291	28.00		
FACILITY OVERHEAD									
29.00	Facility Costs	0	175,766	175,766	-2,992	172,774	29.00		
30.00	Administrative Costs	1,293,924	1,363,790	2,657,714	-244,775	2,412,939	30.00		
31.00	Total Facility Overhead (sum of lines 29 and 30)	1,293,924	1,539,556	2,833,480	-247,767	2,585,713	31.00		
32.00	Total facility costs (sum of lines 22, 28 and 31)	7,039,154	2,170,149	9,209,303	-263,288	8,946,015	32.00		

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN:14-0059

Period:

Worksheet M-1

Component CCN:14-8538

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 11:47 am

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	RHC I	Cost
		6.00	7.00		
FACILITY HEALTH CARE STAFF COSTS					
1.00	Physician	0	2,359,752		1.00
2.00	Physician Assistant	0	364,431		2.00
3.00	Nurse Practitioner	-213,208	1,197,479		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	75,053		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	1,508,934		9.00
10.00	Subtotal (sum of lines 1 through 9)	-213,208	5,505,649		10.00
11.00	Physician Services Under Agreement	0	3,680		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	3,680		14.00
15.00	Medical Supplies	0	624,474		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	624,474		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-213,208	6,133,803		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	13,291		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	13,291		28.00
FACILITY OVERHEAD					
29.00	Facility Costs	0	172,774		29.00
30.00	Administrative Costs	0	2,412,939		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	2,585,713		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-213,208	8,732,807		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES				Provider CCN:14-0059	Period: From 07/01/2020 To 06/30/2021	Worksheet M-2 Date/Time Prepared: 11/30/2021 11:47 am
				Component CCN:14-8538	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	8.16	29,942	4,200	34,272	1.00
2.00	Physician Assistant	2.52	8,229	2,100	5,292	2.00
3.00	Nurse Practitioner	9.98	31,420	2,100	20,958	3.00
4.00	Subtotal (sum of lines 1 through 3)	20.66	69,591		60,522	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	1.16	2,124		2,124	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)	21.82	71,715		71,715	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)				6,133,803	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				13,291	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				6,147,094	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)				0.997838	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)				2,585,713	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				3,519,601	15.00
16.00	Total overhead (sum of lines 14 and 15)				6,105,314	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Enter the amount from line 16				6,105,314	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)				6,092,114	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)				12,225,917	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 07/01/2020 To 06/30/2021	Worksheet M-3	
		Component CCN:14-8538		Date/Time Prepared: 11/30/2021 11:47 am	
		Title XVIII	RHC I	Cost	
			1.00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			12,225,917	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			303,471	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			11,922,446	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			71,715	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)			71,715	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			166.25	7.00
		Calculation of Limit (1)			
		Prior to Jan. 1 (Rate Period 1)	On or After Jan. 1 (Rate Period 2)	On or After Apr. 1 (Rate Period 3)	
		1.00	2.00	3.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	86.31	87.52	160.57	8.00
9.00	Rate for Program covered visits (see instructions)	166.25	166.25	160.57	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	0	12,393	3,994	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,060,336	641,317	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	99	23	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	16,459	3,693	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	16,459	3,693	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	2,721,805		16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,379,481		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		255,123		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		291,826		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.)		1,707,492		16.04
16.05	Total program cost (see instructions)	0	1,999,318		16.05
17.00	Primary payer amounts		164		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		295,614		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		365,749		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,999,154		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		141,117		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,140,271		22.00
23.00	Allowable bad debts (see instructions)		87,472		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		56,857		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		74,041		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)		2,197,128		26.00
26.01	Sequestration adjustment (see instructions)		0		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		1,831,502		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)		365,626		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN:14-0059

Period:

Worksheet M-4

Component CCN:14-8538

From 07/01/2020
To 06/30/2021Date/Time Prepared:
11/30/2021 11:47 am

		Title XVIII		RHC I	Cost	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	5,505,649	5,505,649	5,505,649	5,505,649	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000426	0.001505	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	2,345	8,286	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	70,741	70,880	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	73,086	79,166	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	6,133,803	6,133,803	6,133,803	6,133,803	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	6,092,114	6,092,114	6,092,114	6,092,114	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.011915	0.012907	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	72,588	78,631	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	145,674	157,797	0	0	10.00
11.00	Total number of injections/infusions (from your records)	387	1,366	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	376.42	115.52	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	246	420	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	92,599	48,518	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		303,471			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		141,117			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 07/01/2020 To 06/30/2021	Worksheet M-5	
		Component CCN:14-8538		Date/Time Prepared: 11/30/2021 11:47 am	
		RHC I	Cost		
		Part B			
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC		1,753,771	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		04/19/2021	77,731		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)		77,731		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,831,502		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		365,626		6.01
6.02	SETTLEMENT TO PROGRAM		0		6.02
7.00	Total Medicare program liability (see instructions)		2,197,128		7.00
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00