Heal th Financi	al Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fai	lure to report can r	result in all interim	FORM APPROVED
payments made	since the beginning of the cost	reporting period being	deemed overpayments	; (42 USC 1395g).	OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	T REPORT CERTIFICATION	Provider CCN: 15-00	From 01/01/2015	Worksheet S Parts I-III Date/Time Prepared: 1/16/2018 2:58 pm
PART I - COST	REPORT STATUS				
Provi der use only	 [X] Electronically filed cc [Manually submitted cost [1] If this is an amended r [F] Medicare Utilization. E 	report report enter the number	of times the provide " for low.	Date: 1/16/20 er resubmitted this co	
Contractor use only	5. [5]Cost Report Status 6. (1) As Submitted 7. (2) Settled without Audit 8. (3) Settled with Audit 9. (4) Reopend	Contractor No.	or this Provider CCN		

PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 JOHNSON MEMORIAL HOSPITAL (15-0001) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

(Si gned)

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	12, 845	17, 506	-21, 611	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
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	12, 845	17, 506	-21, 611	0	200.00

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

Date

	h Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DAT		Provi der		5-0001	Period: From 01/01, To 12/31,	/2015 /2015	Worksho Part I Date/Ti	me Pre	pared:
	1.00	2.	00	3.	00			4.00			
1.00	Hospital and Hospital Health Care Co Street: 1125 WEST JEFFERSON STREET	PO Box:									1.00
2.00	City: FRANKLIN	State: I	N Zi	p Code: 4	46131-	Coun	ty: JOHNSON				2.00
		Component Na			CBSA	Provi der			nt Syst		
			Nu	mber N	umber	Туре	Certified		0, or		
		1.00	2	. 00	3.00	4.00	5.00	V 6.00	XVIII 7.00	XIX 8.00	
	Hospital and Hospital-Based Componen		2	. 00	3.00	4.00	5.00	0.00	7.00	0.00	
3.00	Hospi tal	JOHNSON MEMORIAL	15	0001 2	26900	1	07/01/1966	N	Р	0	3.00
		HOSPI TAL									
4.00	Subprovider - IPF					_					4.00
5.00	Subprovider - IRF	TODD AI KENS REHAE	8 15	T001 2	26900	5	01/01/2005	N	P	0	5.00
6.00 7.00 8.00 9.00 10.00 11.00 12.00	Hospital-Based OLTC	CENTER JOHNSON MEMORIAL HEALTH	HOME 15	7510 2	26900		07/01/1997	N	Р	N	6.00 7.00 8.00 9.00 10.00 11.00 12.00
) Hospital-Based Health Clinic – FOHC) Hospital-Based (CMHC) I) Renal Dialysis										13.00 14.00 15.00 16.00 17.00 18.00 19.00
							From:		To		
20.00	1 3 ()))))						<u> </u>		2. 12/31		20.00
	Inpatient PPS Information										
22.00	Does this facility qualify and is it share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en	ance with 42 CFR ity subject to 42	§412.106? CFR Sectio	In colur on §412.	nn 1, €	enter "Y"			Ν	l	22.00
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions)	es or "N" for no October 1. Enter	for the por in column 2	rtion of 2, "Y" fo	the co or yes	ost or "N"	Y		Y	,	22.01
22. 02	! Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1.	? (see instruction e cost reporting	ns) Enter i period prio	in columr or to Oct	ח 1, "א tober ז	Y" for ye 1. Enter			Ν	I	22.02
22.03	of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no	statistical area no for the portio 2, "Y" for yes or r after October 1 t more than 499 b	s adopted b n of the co "N" for no . (see inst eds (as cou	by CMS ir Dost repor Do for the tructions	n FY20 rting p e porti s) Does	15? Enter period ion of th s this	e		Ν	I	22.03
23.00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per	dicaid days on li f census days, or is cost reporting	nes 24 and, 3 if date period di1 <u>, enter "Y</u>	of disch fferent f <u>for yes</u>	narge. From th <u>s or "N</u>	Is the he method <u>N" for no</u>		2	N		23.00
			In-State Medicaid paid days	In-Stat Medicai eligibl unpaid days	d S e Me pai	d days	State H Medi cai d el i gi bl e unpai d	Medicai MO day	/s Med	ther di cai d days	
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6.	<u>1.00</u> 175 31	2.00	359	<u>3.00</u> 0	4.00		570	5. 00 56	24.00

HOSPI T	Financial Systems JOHNSON ! AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		AL HOSPITAL Provider CC		Period: From 01/01/		u of For Workshe Part I		
					To 12/31		Date/Ti		
					Urban/Ru			Geogr	
26.00	Enter your standard geographic classification (not wag	e) sta	tus at the beg	inning of the	1.00	1	2.0	00	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wag reporting period. Enter in column 1, "1" for urban or	e) sta "2" fo	atus at the end or rural. If ap			1			27.00
35. 00	enter the effective date of the geographic reclassific If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35.00
					Begi nni	0	Endi		-
36.00	Enter applicable beginning and ending dates of SCH sta	tus. S	Subscript line	36 for number	- 1.00		2. (00	36.00
7.00	of periods in excess of one and enter subsequent dates If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	s MDH status		0			37.00
7. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for								37. 01
88.00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N		Y/		-
39.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii) or "N" for no. Does the facility meet the mileage requ	? Ente iremer	er in column 1 nts in accordan	"Y" for yes ce with 42	1.00 e Y		2.0 N		39.00
10. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes o Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobe no in column 2, for discharges on or after October 1.	adjust r 1. E	ment? Enter "Y Inter "Y" for y	" for yes or	- N		N		40.00
			· · ·			V 1.00	XVIII 2.00	XI X 3.00	-
5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment	for a	li sproporti onat	e share in ac	cordance	N	N	N	45.00
6. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excep pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III.					N	N	N	46.00
	ls this a new hospital under 42 CFR §412.300 PPS capit <u>Is the facility electing full federal capital payment?</u> Teaching Hospitals					N N	N N	N N	47.00 48.00
6. 00	Is this a hospital involved in training residents in a	pprove	ed GME programs	? Enter "Y"	for yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting pe GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y" "N", complete Wkst. D, Parts III & IV and D-2, Pt. II,	yes or of th , comp	"N" for no in nis cost report plete Worksheet	column 1. lf ing period?	⁻ column 1 Enter "Y"				57.00
	If line 56 is yes, did this facility elect cost reimbu defined in CMS Pub. 15–1, chapter 21, §2148? If yes, c	rsemer omplet	nt for physicia e Wkst. D-5.		as	N			58.00
	Are costs claimed on line 100 of Worksheet A? If yes, Are you claiming nursing school and/or allied health c				9	N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y" f	or yes Y/N	<u>s or "N" for no</u> IME	. <u>(see instru</u> Direct GME	uctions) IME		Di rect	t GME	
(1.00		1.00	2.00	3.00	4.00		5.0		
51.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
51. 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)		0.00	0.0	bo				61.01
01. 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		0.00	0. (bo				61.02
1. 03	ACA). (see instructions) 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		0.00	0.0	00				61.03
01. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	oo				61.04
o1. 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.0	bo				61.05

OSPI TA	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	λΤΑ 	Provider CC	N: 15-0001 Pe Fr Tc	eriod: com 01/01/2015 o 12/31/2015	Worksheet S-2 Part I Date/Time Pre 1/16/2018 2:53	pared
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3. 00	4.00	5.00	
	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0. 00	0.00			61.(
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		- · ·		1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
1.20	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	61.
				·			1.00	
-	ACA Provisions Affecting the Hea Enter the number of FTE resident					od for which	0.00	62.
	your hospital received HRSA PCRE	funding (see instruc	ctions)					
2. 01	Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	riod of HRSA THC prog	gram. (s	see instruction		your hospital	0.00	62.
3. 00	Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co			Ν	63.
					Unweighted FTEs Nonprovider Site		Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after J				This base year	is your cost r	eporting	
	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trair n-primar all nor d non-pr n columr	ed residents y care provider imary care 3 the ratio	0. 00	0. 00	0. 000000	64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
	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				0.00	0.00	0. 000000	

Heal th	Financial Systems		MEMORIAL HOSPITAL			ieu of Form	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	_EX IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/20 o 12/31/20	15 Date/Time 1/16/2018	e Prepared: 3 2:52 pm
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	(col . 1 + 2))	
	Section 5504 of the ACA Current	Year FTE Residents ir	n Nonprovider Setting	1.00 gsEffective fo	2.00 pr cost repo	3.00 rting periods	6
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident 3 the ratio of	0.00	0.	00 0. 00	00000 66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	d Ratio (col (col. 3 + 4))	
(7.00		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 0.00	00000 67.00
					1	. 00 2. 00 3	3. 00
	Inpatient Psychiatric Facility P						
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	pproved GME teaching 004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	, program in the yes or "N" for r s in a new teach yes or "N" for r	most no. (see ni ng no.	N	70.00 0 71.00
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		(IRF), or does it o	contain an IRF		Y	75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	pproved GME teaching ember 15, 2004? Enter new teaching program for no. Column 3: If	program in the - "Y" for yes or n in accordance f column 2 is Y,	"N" for with 42	N	0 76.00
						1.00	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				period? Ente	er N	80.00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded unit) under			D. N	85. 00 86. 00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			(1)(B)(iv)(II)?	? Enter "Y"	N	87.00
					V	XI X	
	Title V and XIX Services				1.00	2.00	
90.00	Does this facility have title V yes or "N" for no in the applica		hospital services? E	Enter "Y" for	N	Y	90.00
91.00	Is this hospital reimbursed for full or in part? Enter "Y" for y	title V and/or XIX th			N	Y	91.00
92.00	Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certificat			N	92.00
93.00	instructions) Enter "Y" for yes Does this facility operate an IC	F/IID facility for pu		nd XIX? Enter	N	N	93.00
94.00	"Y" for yes or "N" for no in the Does title V or XIX reduce capit applicable column.		or yes, and "N" for r	no in the	N	N	94.00

Health Financial Systems JOHNSON MEMORIA				Lieu		CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		eriod: rom 01/01/2 p 12/31/2			e Prepared:
			V		XI X	8 2:52 pm
			1.00		2.00	
95.00 If line 94 is "Y", enter the reduction percentage in the app96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	olicable column s or "N" for no	n. pinthe	0. 00 N		0.00 N	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers		n.	0.00		0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		nod of payment	N N			105.00 106.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see instr 25 and the pr	ructions) lf rogram is cost	N			107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupational	N Speech		Respi rat	108.00
	1.00	2.00	3.00		4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N	109.00
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	A Demo)for		1.00 N	110.00
	101 110.		-	1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub.15-1, chapter 22, §2208.1.	lf column 2 i nt for long ter	is "E", enter i rm care (incluc	n column les	N		0 115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insur			N" for	N Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy i	s	2		118.00
		Premi ums	Losses	6	Insurar	nce
		1.00	2.00		3.00	
118.01 List amounts of malpractice premiums and paid losses:		395, 247		1, 504	3.00	0 118. 01
			1.00		2.00	
 118. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 119. 00 D0 NOT USE THIS LINE 			N			118.02
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu		' for yes or	N		Ν	120.00
Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.						
Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost impla	nts? (see instr	ructions)	Y			121.00
 Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th 	nts? (see instr nntable devices Enter "Y" for	ructions) s charged to yes or "N"	Y			121. 00 122. 00
 Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 	nts? (see inst antable devices Enter "Y" for ne Worksheet A	ructions) s charged to yes or "N" line number	N			122.00
 Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 	nts? (see instr antable devices Enter "Y" for ne Worksheet A pr yes and "N"	ructions) s charged to yes or "N" line number for no. If				122.00
 Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 	nts? (see instr antable devices Enter "Y" for he Worksheet A or yes and "N" hter the certin	ructions) s charged to yes or "N" line number for no. If fication date	N			122. 00 125. 00 126. 00
 Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en 	nts? (see instr antable devices Enter "Y" for he Worksheet A or yes and "N" hter the certifi er the certifi	ructions) s charged to yes or "N" line number for no. If fication date cation date	N			122.00
 Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, enter 	nts? (see inst antable devices Enter "Y" for ne Worksheet A or yes and "N" nter the certifi 2. eer the certifi 2.	ructions) s charged to yes or "N" line number for no. If fication date cation date	N			122. 00 125. 00 126. 00 127. 00
 Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ent column 1 and termination date, if applicable, in column 2 130.00 If this is a Medicare certified pancreas transplant center, 	nts? (see insti- antable devices Enter "Y" for he Worksheet A or yes and "N" hter the certifi ar the certifi er the certifi er the certific enter the certific	ructions) s charged to yes or "N" line number for no. If fication date ication date cation date cation date in	N			122. 00 125. 00 126. 00 127. 00 128. 00
 Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified liver transplant center, ent column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, enter 	nts? (see insti- antable devices Enter "Y" for ne Worksheet A or yes and "N" nter the certifi 2. er the certifi 2. er the certifi 2. er the certifi 2. enter the certifi anter the certifi antet	ructions) s charged to yes or "N" line number for no. If fication date cation date cation date in tification	N			122.00 125.00 126.00 127.00 128.00 129.00

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-0001		od: 01/01/2015	Worksheet S-2 Part I	
				To	12/31/2015	Date/Time Pre	pared:
						1/16/2018 2:5	2 pm
					1.00	2.00	-
133.00 If this is a Medicare certified ot			cation da	te			133.00
in column 1 and termination date, 134.00 If this is an organ procurement or	if applicable, in column 2 ganization (OPO) enter th	e OPO number i	n column	1			134.00
and termination date, if applicabl							101.00
All Providers		<u></u>			N	1	1.10.00
140.00 Are there any related organization chapter 10? Enter "Y" for yes or "					N		140.00
are claimed, enter in column 2 the	home office chain number.	(see instruct					
1.00 If this facility is part of a chai	2.00		uah 143 th		3.00	of the	
home office and enter the home off						of the	
141.00Name:	Contractor's Name:		Contra	actor's I	Number:		141.00
142.00 Street: 143.00 Ci ty:	PO Box: State:		Zip C	ode:			142.00 143.00
110.00 0129.	Joraro.		210 0	040.			110.00
		2				1.00	111.00
144.00 Are provider based physicians' cos	TS Included in Worksheet A	<u>/</u>				Y	144.00
					1.00	2.00	
145.00 If costs for renal services are cl				_	N	N	145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"	for no in column 2.		. 0				
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir				lf	N		146.00
yes, enter the approval date (mm/c		5-2, chapter 4	0, 94020)				
147.00 Was there a change in the statisti	cal basis? Enter "Y" for y	es or "N" for	no			1.00 N	147.00
148.00 Was there a change in the order of						N	148.00
149.00 Was there a change to the simplifi	ed cost finding method? En				T: 11 1/	N	149.00
		Part A 1.00	Part 2.00		Title V 3.00	Title XIX 4.00	-
Does this facility contain a provi		exemption from	n the appl	ication	of the lowe	er of costs	
or charges? Enter "Y" for yes or " 155.00Hospi tal	N" for no for each compone	<u>nt for Part A</u> N	and Part N	B. (See	42 CFR §413 N	3. 13) N	155.00
156. 00 Subprovi der – TPF		N	N		N	N	156.00
157.00 Subprovider - IRF		N	Ν		N	N	157.00
158. 00 SUBPROVI DER		N	N		N	N	158.00
159.00 SNF 160.00 HOME HEALTH AGENCY		N	N N		N N	N N	159.00 160.00
161. 00 CMHC			N		N	N	161.00
						1.00	-
Multicampus						1.00	
165.00 Is this hospital part of a Multica	mpus hospital that has one	or more campu	ıses in di	fferent	CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Cod	e CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each						0.00	166.00
campus enter the name in column O, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
	-	-				1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful user						Y	167.00
168.00 If this provider is a CAH (line 10					er the		168.00
reasonable cost incurred for the H	IIT assets (see instruction	s)					1/0 00
168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?					rasni p		168.01
169.00 If this provider is a meaningful u	iser (line 167 is "Y") and				enter the	0. 25	169. 00
transition factor. (see instruction	ns)						

Health Financial Systems JOHNSON	N MEMORIAL HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Period: From 01/01/2015	Worksheet S-2 Part I	
		o 12/31/2015		
		Begi nni ng	Endi ng	
		1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and period respectively (mm/dd/yyyy)	ending date for the reporting	01/01/2015	12/31/2015	170.00
				1
		1.00	2.00	
171.00 If line 167 is "Y", does this provider have any days section 1876 Medicare cost plans reported on Wkst. S "Y" for yes and "N" for no in column 1. If column 1 1876 Medicare days in column 2. (see instructions)	S-3, Pt. I, line 2, col. 6? Enter	Y	C	171.00

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 1/16/2018 2:5	epared:
				Y/N	Date	_
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	sponses Ent	1.00	2.00	
	mm/dd/yyyy format.		Sponses. Ente		ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	beginning of	the cost	N		1.0
	reporting period: IT yes, enter the date of the change in c	01 01111 2. (366	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.0
			Y/N	Туре	Date	
	Financial Data and Dan-st-		1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A	04/29/2016	4.0
6. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N	Y/N	Legal Oper.	5.0
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6. C
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		d during the	N N		7. C 8. C
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		cal education	Ν		9.0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, cost instructions		the current	Ν		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.0
				-	Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I1	fyes, see in:	structi ons.	N	14.0
5.00	Did total beds available change from the prior cost reporti	<u>v</u> 1	yes, see ins [.] rt A	tructions. Par	Y t B	15. C
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	04/28/2016	Y	04/28/2016	16. 0
7.00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for	Ν		N		17.0
0.00	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)					
8. 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 property.	Ν		N		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. (

·····	HNSON MEMORIA		ON 15 0001		eu of Form CM	
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	UNNAI RE	Provider C	CN: 15-0001	Period: From 01/01/201 To 12/31/201	5 Date/Time F	Prepared
		Descr	ption	Y/N	1/16/2018 2 Y/N	2:52 pm
)	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made Report data for Other? Describe the other adjus				Ν	N	20. 0
	_	Y/N	Date	Y/N	Date	
01.00 West the sector sector sector set of the sector	ut de et e	1.00	2.00	3.00	4.00	01.0
21.00 Was the cost report prepared only using the pro- records? If yes, see instructions.	vider s	N		N		21. (
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS Capital Related Cost	S ONLY (EXCEF	PT CHILDRENS H	OSPI TALS)			
22.00 Have assets been relifed for Medicare purposes?						22. (
3.00 Have changes occurred in the Medicare depreciat reporting period? If yes, see instructions.	•			0		23.
4.00 Were new leases and/or amendments to existing lease instructions		Ũ				24.
5.00 Have there been new capitalized leases entered instructions.	C C		0.1	5		25.0
26.00 Were assets subject to Sec. 2314 of DEFRA acquire instructions.	Ū.		0.1	5		26.
27.00 Has the provider's capitalization policy change copy. Interest Expense	d during the	cost reportir	ig period? If	yes, submit		27.
8.00 Were new loans, mortgage agreements or letters period? If yes, see instructions.	of credit ent	tered into dur	ing the cost	reporting		28.
9.00 Did the provider have a funded depreciation accute treated as a funded depreciation account? If ye			bt Service F	Reserve Fund)		29.
Has existing debt been replaced prior to its scl instructions.			debt? If yes	s, see		30.
1.00 Has debt been recalled before scheduled maturity instructions. Purchased Services	y without iss	suance of new	debt? If yes	s, see		31.
Have changes or new agreements occurred in pati- arrangements with suppliers of services? If yes 3.00 If line 32 is yes, were the requirements of Sec	, see instruc	ctions.	C		f	32. 33.
no, see instructions. Provider-Based Physicians						
4.00 Are services furnished at the provider facility	under an arr	angement with	provi der-ba	ased physi ci ans?		34.
5.00 If line 34 is yes, were there new agreements or	amended exis	sting agreemer	ts with the	provi der-based		35.
physicians during the cost reporting period? If	yes, see ins	structions.			Data	_
				Y/N 1.00	Date 2.00	
Home Office Costs				1.00	2.00	
6.00 Were home office costs claimed on the cost repo						36.
7.00 If line 36 is yes, has a home office cost state If yes, see instructions.	ment been pre	epared by the	home office?	>		37.
8.00 If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the fisc	the home offi cal vear end	ce different of the home c	from that of office.	-		38.
9.00 If line 36 is yes, did the provider render serv see instructions.				5,		39.
0.00 If line 36 is yes, did the provider render serv instructions.	ices to the h	nome office?	lf yes, see			40.
	_	1	00		2 00	
Cost Report Preparer Contact Information		1.	00		2. 00	
1.00 Enter the first name, last name and the title/p held by the cost report preparer in columns 1, 2		II CHOLAS		EI CHELMAN		41.
2.00 Enter the employer/company name of the cost rep	ort E	3KD, LLP				42.
preparer.						

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der	CCN: 15-0001	Period:	Worksheet S-2	
					From 01/01/2015 To 12/31/2015		pared: 2 pm
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	itle/position S	SR. MANAGER				41.00
	held by the cost report preparer in column	ns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cos	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addre	ess of the cost					43.00
	report preparer in columns 1 and 2, respe	cti vel y.					

	Financial Systems	JOHNSON MEMORI				eu of Form CMS-2	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	al data	Provider CC	JN: 15-0001	Period: From 01/01/2015 To 12/31/2015		pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	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	80				1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		80	29, 2	00 0.00	0	7.00
8.00 9.00 10.00 11.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31.00	6	2, 1	90 0.00	0	8.00 9.00 10.00 11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00				0	12.00 13.00
14.00 15.00 16.00	Total (see instructions) CAH visits SUBPROVIDER - IPF		86	31, 3	90 0.00	0	14.00 15.00 16.00
17.00 18.00 19.00 20.00 21.00	SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	41.00	11	5, 1	07	0	17.00 18.00 19.00 20.00 21.00
22. 00 23. 00 24. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	101.00				0	22.00 23.00 24.00
24.10 25.00 26.00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30.00					24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	89.00	97			0	26.25 27.00 28.00 29.00 30.00 31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days		0		0		32.00 32.01 33.00

HOSPI T	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	AL DATA	Provider CO		Period: From 01/01/2015 To 12/31/2015		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	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)	2, 448	132	4, 70			1.00
2.00	HMO and other (see instructions)	896	1, 029				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	96	175				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 448	132	4, 70	2		7.00
8.00	INTENSIVE CARE UNIT	256	26	93	5		8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		18	65	0		13.00
14.00	Total (see instructions)	2, 704	176	6, 28	7 0.00	523.88	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER – IRF	503	31	1, 19	1 0.00	10.34	17.00
18.00	SUBPROVI DER						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	3, 473	287	6, 77	9 0.00	10.59	
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00			0		~		24.00
24.10	HOSPICE (non-distinct part)	0	0		0		24.10
25.00	CMHC - CMHC						25.00
26.00 26.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.00 26.25
20.25		0	0		0.00		26.25
27.00	Total (sum of lines 14-26) Observation Bed Days		0	89		544.01	27.00
28.00	Ambulance Trips	0	0	07	3		28.00
30.00	Employee discount days (see instruction)	0			0		30.00
31.00	Employee discount days (see Fisting Charles)				0		31.00
32.00	Labor & delivery days (see instructions)	0	56	12			31.00
32.00	Total ancillary labor & delivery room	0	50		0		32.00
52.01	outpatient days (see instructions)				Ĭ		52.01
22.00	LTCH non-covered days	0					33.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	JOHNSON MEMORIAL	Provider C	°N· 15-0001	Peri od:	u of Form CMS-2 Worksheet S-3	2002-10
	AL AND HOST THE HEALTH GARE GOM LEA STATISTIC				From 01/01/2015 To 12/31/2015	Part I Date/Time Prep 1/16/2018 2:52	
		Full Time Equivalents		Di se	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	71	3 257	1, 792	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			22	24 0 0 0		2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00	I NTEŃSÌ VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF	0. 00	0	71	3 257	1, 792	13.00 14.00 15.00 16.00
17.00 17.00 18.00 19.00 20.00 21.00	SUBPROVIDER - IRF SUBPROVIDER - IRF SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00	0	3	38 5	85	10.00 17.00 18.00 19.00 20.00 21.00
22.00 23.00 24.00 24.10 25.00 26.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00					22.00 23.00 24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

SPI I.	AL WAGE INDEX INFORMATION			Provider CC		eriod: rom 01/01/2015 o 12/31/2015		pare
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adj usted Sal ari es (col . 2 ± col . 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
00	Total salaries (see	200.00	33, 750, 187	0	33, 750, 187	1, 133, 203. 00	29. 78	1
	instructions)	2001 00	00,700,107	Ű	00,700,107	1, 100, 2001 00	2/1/0	
00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2
00	A Non-physician anesthetist Part		O	0	0	0.00	0.00	3
.0	B		0	Ŭ	0	0.00	0.00	
00	Physician-Part A -		0	0	0	0.00	0.00	4
)1	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	4
0	Physician and Non		0	-	0			
	Physician-Part B							
00	Non-physician-Part B for		0	0	0	0.00	0.00	6
	hospital-based RHC and FQHC services							
00	Interns & residents (in an	21.00	0	0	0	0.00	0.00	7
	approved program)							
)1	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7
	programs)							
00	Home office and/or related		0	0	0	0.00	0.00	8
00	organization personnel	44.00	0		0	0.00	0.00	
00	SNF Excluded area salaries (see	44.00	10, 628, 722	-113, 345	10, 515, 377	0.00 229,429.00		
00	instructions)		10, 020, 722	110, 010	10, 010, 077	227, 127.00	10.00	
	OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient Care		1, 067, 721	0	1, 067, 721	12, 820. 00	83. 29	11
00	Contract Labor: Top Level		196, 087	0	196, 087	6, 158. 00	31.84	12
	management and other management and administrative services							
00	Contract Labor: Physician-Part		115, 074	0	115, 074	1, 653. 00	69.62	13
	A - Administrative					,		
00	Home office and/or related		0	0	0	0.00	0.00	14
	orgainzation salaries and wage-related costs							
01	Home office salaries		0	0	0	0.00	0.00	14
02	Related organization salaries		0	-	0	0.00		
00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15
00	Home office and Contract		O	0	0	0.00	0.00	16
	Physicians Part A - Teaching			_				
~~	WAGE-RELATED COSTS		F F24 170		F F2(170			1
00	Wage-related costs (core) (see instructions)		5, 536, 178	0	5, 536, 178			17
00	Wage-related costs (other)		0	0	0			18
00	(see instructions)		1 405 005		1 405 005			
00 00	Excluded areas Non-physician anesthetist Part		1, 405, 395 0	0	1, 405, 395 0			19
	A		0		0			_
00	Non-physician anesthetist Part		0	0	0			21
00	B Physician Part A -		0		^			22
00	Admi ni strati ve		0		0			~
01	Physician Part A - Teaching		0	-	0			22
00	Physician Part B		0	0	0			23
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		U O	0	0			24
	approved program)		0		0			
50	Home office wage-related							25
51	Related orgainzation wage-related							25
52	Home office: Physician Part A - Administrative -							25
E 2	wage-related							<u>~</u> -
53	Home office & Contract Physicians Part A - Teaching -							25
	wage-related							
	OVERHEAD COSTS - DI RECT SALARI E		0.040.007	110.01-	0.0/0.470	14/ 105 00	00.07	
υU	Employee Benefits Department Administrative & General	4.00 5.00	2, 848, 827 1, 860, 549					

Heal th	Financial Systems		JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 1/16/2018 2:5	pared: 2 pm
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
	1	1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		217, 575	0	217, 57	5 795.00	273. 68	28.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	608, 085	0	608, 08	5 29, 384. 00	20.69	30.00
31.00	Laundry & Linen Service	8.00	119, 960	0	119, 96	0 9, 473. 00	12.66	31.00
32.00	Housekeepi ng	9.00	640, 436	0	640, 43	6 53, 447. 00	11. 98	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	748, 737	-455, 969	292, 76	8 18, 603. 00	15. 74	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	455, 969	455, 96	9 28, 974. 00	15. 74	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	1, 274, 566	0	1, 274, 56	6 23, 229. 00	54.87	38.00
39.00	Central Services and Supply	14.00	73, 222	0	73, 22	2 4, 263.00	17. 18	39.00
40.00	Pharmacy	15.00	453, 149	0	453, 14	9 12, 587.00	36.00	40.00
41.00	Medical Records & Medical Records Library	16.00	477, 397		477, 39			
42.00	Social Service	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0.00		43.00

Heal th	Financial Systems		JOHNSON MEMOR	I AL_HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	
							1/16/2018 2:5	
		Worksheet A		Recl assi fi cati	, J		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		33, 967, 762	0	33, 967, 76	2 1, 133, 998. 00	29.95	1.00
	instructions)							
2.00	Excluded area salaries (see		10, 628, 722	-113, 345	10, 515, 37	7 229, 429. 00	45.83	2.00
	instructions)							
3.00	Subtotal salaries (line 1		23, 339, 040	113, 345	23, 452, 38	5 904, 569. 00	25.93	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 378, 882	0	1, 378, 88	2 20, 631. 00	66.84	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		5, 536, 178	0	5, 536, 17	8 0.00	23.61	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		30, 254, 100	113, 345	30, 367, 44	5 925, 200. 00	32.82	6.00
7.00	Total overhead cost (see		9, 322, 503					7.00
	instructions)		., 022, 000	1.07010	., 100,01			
		1		1	I	1	I	

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provider CCN:	15-0001	Period: From 01/01/2015 To 12/31/2015		pared:
	·					Amount	2 μπ
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Cor					0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (0	3.00
4.00	Qualified Defined Benefit Plan Cost (see					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to Exter	nal Organization)					
5.00	401K/TSA Plan Administration fees					900, 490	5.00
6.00	Legal /Accounting/Management Fees-Pensior					0	6.00
7.00	Employee Managed Care Program Administra	tion Fees				374, 688	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Func					3, 036, 118	
8.01	Health Insurance (Self Funded without a						8.01
8.02	Health Insurance (Self Funded with a Thi	rd Party Administrato	r)				8.02
8.03	Health Insurance (Purchased)						8.03
9.00	Prescription Drug Plan					0	
10.00	Dental, Hearing and Vision Plan					0	
	Life Insurance (If employee is owner or					34, 447	
	Accident Insurance (If employee is owner					0	
13.00	Disability Insurance (If employee is owr		、 、			97, 983	
	Long-Term Care Insurance (If employee is	owner or beneficiary)			0	
15.00	'Workers' Compensation Insurance			-1	L L FACD 10/	255, 680	
16.00	Retirement Health Care Cost (Only currer Non cumulative portion)	t year, not the extrac	ordinary accru	ai require	ed by FASB 106.	0	16.00
	TAXES						
17 00	FICA-Employers Portion Only					2, 254, 578	17 00
	Medicare Taxes - Employers Portion Only						18.00
	Unemployment Insurance					41.957	
	State or Federal Unemployment Taxes						20.00
20.00	OTHER					0	20.00
21.00	Executive Deferred Compensation (Other 1	nan Retirement Cost Re	eported on lin	es 1 throu	ugh 4 above. (see	0	21.00
211.00	instructions))		opor tou on thi		ight i aborton (ooo		200
22.00	Day Care Cost and Allowances					0	22.00
	Tuition Reimbursement					37, 339	
	Total Wage Related cost (Sum of lines 1	-23)				7, 033, 280	
	Part B - Other than Core Related Cost						

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0001	Peri od:	Worksheet S-3	
				From 01/01/2015 To 12/31/2015		nared
				10 12/31/2013	1/16/2018 2:5	
	Cost Center Description			Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi					
1.00	Total facility's contract labor and benefit	cost		0		1.00
2.00	Hospi tal			0	0	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF			0	0	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			0	0	11.00
12.00	Separately Certified ASC					12.00
13.00	Hospi tal -Based Hospi ce					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
	Renal Dialysis					17.00
18.00	Other			0	0	18.00

	Financial Systems IEALTH AGENCY STATISTICAL DATA	JOHNSON MEMORI	Provider C	F	In Lie Period: From 01/01/2015 To 12/31/2015 Home Health Agency I		pared:
						00	-
0.00	County				1.	00	0.00
0.00	loounty	Title V	Title XVIII	Title XIX	Other	Total	0.00
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA			1			
1.00 2.00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00					1.00 2.00
2.00	Tondup reated census count (see first detrons)	0.00	158.00		loyees (Full Ti		2.00
		Enter the numb your normal		Staff	Contract	Total	
				1.00	2.00	2.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES)	1.00	2.00	3.00	
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 20. 01 20. 02	Administrator and Assistant Administrator(s) Director(s) and Assistant Director(s) Other Administrative Personnel Direct Nursing Service Nursing Supervisor Physical Therapy Service Physical Therapy Supervisor Occupational Therapy Supervisor Speech Pathology Service Speech Pathology Supervisor Medical Social Service Medical Social Service Medical Social Service Home Health Aide Home Health Aide Supervisor Other (specify) HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where you provided services during the cost reporting period. List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	Full Ep		0.00 2.25 4.22 0.00 1.67 0.00	0 0.00 5 0.00 4 0.00 7 0.00 9 0.00 9 0.00 9 0.00 9 0.00 9 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00	0.00 2.25 4.24 0.00 1.67 0.00 0.05 0.00 0.05 0.00 0.01 0.00 0.02 0.00 0.02	$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
21.00	PPS ACTIVITY DATA Skilled Nursing Visits	1,617	15	22		1, 660	21.00
21.00	Skilled Nursing Visit Charges	371, 910					
23.00	Physical Therapy Visits	984			5 7	1, 021	
24.00	Physical Therapy Visit Charges	246, 000			1, 750	255, 250	24.00
25.00	Occupational Therapy Visits	714		1	5 7	740	
26.00 27.00	Occupational Therapy Visit Charges Speech Pathology Visits	178, 500 18		1, 250	1,750	185, 000 18	
27.00	Speech Pathology Visit Charges	4, 500			0 0	4, 500	
29.00	Medical Social Service Visits	4	0	0	0 0	4	
30.00	Medical Social Service Visit Charges	1,080		0	0	1, 080	
31.00	Home Health Aide Visits	30			-	30	
32.00 33.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	3, 000 3, 367	0 54		-	3, 000 3, 473	
55.00	29, and 31)	3, 307	54	32	20	3,473	33.00
34.00	Other Charges	13, 823	о	42	2 0	13, 865	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28,	818, 813					
	30, 32, and 34)						
36.00	Total Number of Episodes (standard/non outlier)	0			0 0	0	36.00
37.00 38.00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	0	0	1	0	-	
55.00	The second second supply charges	. 0	. 0		- - -	. 0	00.00

Medicaid (see instructions for each line)	Heal th	Financial Systems JOHNSON MEMORIAL H	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
Incompensated and indigent care cost computation Incompensated and indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 6) 0.272128 2.00 Net revenue from Modical d 0.27128 2.00 Net revenue from Modical d 0.27128 2.00 Net revenue from Modical d 0.27128 2.00 Net revenue from Modical d 1.00 2.00 Net revenue from Modical d 1.00 3.00 Did you receive USA or supplemental payments from Modical d? N 4.00 Net revenue from set revenue and costs for Medical d program (line 7 minus sum of lines 2 and 5: If 0.00 6.00 Net revenue from stand-alone CHP 0.00 0.00 0.01 Stand-alone CHP cost (line 1 times line 10) 0.10.00 0.10.00 10.00 Stand-alone CHP cost (line 1 times line 10) 0.10.00 10.00 10.00 10.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10.00 0.10.00 11.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10.00 0.10.00 <			Provider CCM	N: 15-0001	Peri od:	Worksheet S-1	
Image: constructions Image: constructions Image: constructions 1.00 Cost to charge ratio (Worksheet C, Part I line 202 colum 3 divided by line 202 colum 8) 0.291285 2.00 Madical (see Instructions for each line) 0.291285 2.00 Didy or receive 0810 or supplemental payments from Medicaid 7 Y. 153, 124 2.0 4.00 If line 3 is and, then enter DSH or supplemental payments from Medicaid 7 Y. 60, 786 5.0 0.00 Medicaid cost (line 1 times is used to supplemental payments from Medicaid 7 Y. 60, 786 5.0 0.00 Medicaid cost (line 1 times is supplemental payments from Medicaid 7 Y. 60, 786 5.0 0.00 Medicaid cost (line 1 times ine 0) 2.0 9.00 9.00 9.00 0.00 Stand-alone CHP cost (line 1 times line 10) 10.00 5.00 9.00 10.00 10.00 Stand-alone CHP cost (line 1 times time 10) 10.00 10.00 10.00 11.00 11.00 Stand-alone CHP cost (line 1 times time 10) 11.00 11.00 11.00 11.00 12.00 Difference between net revenue and costs for stand-alone CHP (line 11 minus line 9.116						Date/Time Pre	
Incompensated and indigent care cost computation Incompensated and indigent care program (line 202 colum 8) 0.291285 1.0 1.00 Cost to charge ratio (Worksheet C, Part L Hine 202 colum 3) 0.291285 1.0 0.291285 1.0 2.00 Net revenue from Medicald 7, 153, 122 0.0 7, 153, 122 0.0 3.00 Did you receive DSH or supplemental payments from Medicald? Y 4.0 7, 153, 122 0.0 3.00 Did for a size (a do size) 1.0 7, 153, 122 0.0 7, 153, 122 0.0 3.00 Medical charges 1.0 1.0 7, 153, 122 0.0 0.0 1.0 <							
1.00 Cost to charge ratio (Worksheet C, Part Line 202 column 3 divided by line 202 column 8) 0.291285 1.0 2.00 Net revenue from Medicaid 7, 153, 124 2.0 3.00 Did you receive DSI or supplemental payments from Medicaid? Y 3.0 4.00 IF line 4 is no, then enter DSI or supplemental payments from Medicaid Y 3.0 0.00 Medicaid cost (line 1 times line 6) 20:172,705 6.00 0.01 Medicaid cost (line 1 times line 6) 20:172,705 6.00 0.00 Net revenue from Stand-alone CHP program (CHP) (see instructions for each line) 0 9.00 9.00 Net revenue from stand-alone CHP program (cHP) (see instructions for each line) 0 10.0 12.00 Difference between net revenue and costs for stand-alone CHP (line 11 minus line 9; if < zero then enter zero)		Uncomponented and indigent care cost computation				1.00	
Medicald (see Instructions for each line) Instructions 2.00 Net revenue from Medicaid 7, 153, 12 2.0 3.00 Did you receive DSH or supplemental payments from Medicaid? Y 4.0 3.00 If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid 7, 153, 12 2.0 3.00 Medicaid charges 29, 172, 705 6.0 9.09, 786 5.00 3.00 Medicaid cost (line 1 times line 6) Medicaid cost (line 1 times line 6) 8.497, 571 7.0 6.00 Medicaid cost (line 1 times line 6) 9.0 0.10 10.0 8.497, 571 7.0 0.00 Difference between ther venue and costs for stand-alone CHP 0 9.0 0.10.0 0.00 Difference between ther venue and costs for stand-alone CHP (line 11 minus line 9, if < zero then ent revenue and costs for state-or local indigent care program (Not included on lines 2, 5 or 9)	1 00		ided by lin	e 202 column	8)	0 291285	1.00
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 or supplemental payments from Medicaid? N 4.0 5.00 IF line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid? N 4.0 5.00 Medicaid charges 0 1,969,786 5.00 7.00 Medicaid cost (line 1 times line 6) 8.497,571 7.00 8.497,571 7.00 8.00 DIfference between and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 9 0 9.0 9.00 Net revenue from stand-alone CHP 0 9.0 <td></td> <td></td> <td>ruou by rin</td> <td>10 202 001 dilli</td> <td></td> <td>01271200</td> <td></td>			ruou by rin	10 202 001 dilli		01271200	
4.00 If Ine 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid? N 4.00 5.00 IF Ine 4 is no. then enter DSH or supplemental payments from Medicaid 1,969,786 5.02 6.00 Medicaid charges 29,172,705 6.00 7.00 Medicaid charges 29,172,705 6.00 8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if 0 8.00 Stand-alone CHIP charges 0 0.0 10.00 Stand-alone CHIP cost (line 1 times line 10) 0 10.0 12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	2.00	Net revenue from Medicaid				7, 153, 124	2.00
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24.00Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limitN24.025.00If line 24 is yes, enter the charges for patient days beyond the indigent care program?If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)5, 331, 46326.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)5, 331, 46326.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359, 69527.0028.00Non-Medicare bad debt expense (line 26 minus line 27.01)4, 971, 76828.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1, 574, 09429.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2, 690, 30930.00							
imposed on patients covered by Medicaid or other indigent care program?25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)5, 331, 46326.027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)5, 331, 46326.027.01Medicare allowable bad debts for the entire hospital complex (see instructions)233, 80227.028.00Non-Medicare bad debt expense (line 26 minus line 27.01)4, 971, 76828.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1, 574, 09429.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2, 690, 30930.00	24.00	Door the amount in Line 20 column 2 include charges for notiont	dave bayon	d a longth g	f ctov limit		24.00
25.00If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit025.0026.00Total bad debt expense for the entire hospital complex (see instructions)5, 331, 46326.0027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)5, 331, 46326.0027.01Medicare allowable bad debts for the entire hospital complex (see instructions)23, 80227.0028.00Non-Medicare bad debt expense (line 26 minus line 27.01)4, 971, 76828.0029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1, 574, 09429.0030.00Cost of uncompensated care (line 23 column 3 plus line 29)2, 690, 30930.00	24.00			iu a renyth c	i Stay i i ilii t	IN IN	24.00
26.00Total bad debt expense for the entire hospital complex (see instructions)5, 331, 46326.027.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)233, 80227.027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359, 69527.028.00Non-Medicare bad debt expense (line 26 minus line 27.01)4, 971, 76828.029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1, 574, 09429.030.00Cost of uncompensated care (line 23 column 3 plus line 29)2, 690, 30930.0	25.00	If line 24 is yes, enter the charges for patient days beyond th		care program	's length of	0	25.00
27.00Medicare reimbursable bad debts for the entire hospital complex (see instructions)233,80227.027.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,69527.028.00Non-Medicare bad debt expense (line 26 minus line 27.01)4,971,76828.029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,574,09429.030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,690,30930.0	26 00		structions)			5 331 463	26 00
27.01Medicare allowable bad debts for the entire hospital complex (see instructions)359,69527.028.00Non-Medicare bad debt expense (line 26 minus line 27.01)4,971,76828.029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,574,09429.030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,690,30930.0				uctions)			
28.00Non-Medicare bad debt expense (line 26 minus line 27.01)4,971,76828.029.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,574,09429.030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,690,30930.0							
29.00Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)1,574,09429.030.00Cost of uncompensated care (line 23 column 3 plus line 29)2,690,30930.0				- /			
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 2,690,309 30.0	29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see i	nstructions)		1, 574, 094	29.00
						2, 690, 309	30.00
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 2,690,309 31.0	31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			2, 690, 309	31.00

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (JOHNSON MEMORIA OF EXPENSES	L HOSPITAL Provider CO	CN: 15-0001 F	In Lie Period:	u of Form CMS-: Worksheet A	2552-10
			F	rom 01/01/2015 o 12/31/2015	Date/Time Pre 1/16/2018 2:5	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT		1, 746, 722	1, 746, 722		1, 746, 722	1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER		86, 509			86, 509	1.01
2. 00 00200 CAP REL COSTS-MVBLE EQUI P		2, 703, 810			2, 703, 810	•
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS	242, 108 197, 347	7, 082, 964 276, 668			7, 454, 575 474, 015	4.00
4. 02 00402 DATA PROCESSING	759, 339	665, 472			1, 424, 811	4.01
4. 03 00403 MATERIALS MANAGEMENT	229, 947	46, 951	276, 898		276, 898	4.03
4. 04 00404 ADMI TTI NG	570, 159	30, 095			600, 254	4.04
4. 05 00405 PATLENT ACCOUNTING 5. 00 00500 ADMINISTRATIVE & GENERAL	849, 927	634, 275 4, 392, 283	1, 484, 202		1, 484, 202	4.05 5.00
7.00 00700 OPERATION OF PLANT	1, 860, 549 608, 085	4, 392, 203 1, 978, 812			6, 252, 832 2, 586, 897	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	119, 960	70, 856			190, 816	
9. 00 00900 HOUSEKEEPI NG	640, 436	113, 296			753, 732	•
10. 00 01000 DI ETARY	748, 737	310, 910			414, 344	•
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON	0 1, 274, 566	0 223, 734	0 1, 498, 300	,	645, 303 1, 498, 300	•
14. 00 01400 CENTRAL SERVICES & SUPPLY	73, 222	108, 800			182, 022	•
15.00 01500 PHARMACY	453, 149	3, 425, 564	3, 878, 713		3, 878, 713	
16.00 01600 MEDICAL RECORDS & LIBRARY	477, 397	245, 233	722, 630	0	722, 630	16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2, 970, 575	748, 775	3, 719, 350	-202, 175	3, 517, 175	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 081, 414	111,047			1, 192, 461	31.00
41. 00 04100 SUBPROVI DER – I RF	586, 250	138, 335			724, 585	41.00
43. 00 04300 NURSERY	0	0		202, 175	202, 175	43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1, 735, 743	728, 784	2, 464, 527	0	2 464 527	50.00
53. 00 05300 OPERATING ROOM 53. 00 05300 ANESTHESI OLOGY	1, 735, 745	20, 563			2, 464, 527 20, 563	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 961, 053	936, 022			2, 897, 075	•
60. 00 06000 LABORATORY	1, 397, 547	1, 751, 458			3, 149, 005	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	853, 705	145, 627	999, 332		999, 332	•
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	690, 130 210, 129	45, 382 26	735, 512 210, 155		735, 512 210, 155	
68. 00 06800 SPEECH PATHOLOGY	121, 646	6, 206	127, 852		127, 852	•
69. 00 06900 ELECTROCARDI OLOGY	391, 596	307, 177	698, 773		698, 773	
70. 00 07000 ELECTROENCEPHALOGRAPHY	47, 216	7, 229			54, 445	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 074, 054 0	3, 074, 054		1, 622, 765 1, 451, 289	•
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			1, 431, 209	73.00
76. 00 03020 ONCOLOGY	149, 713	30, 145	179, 858		179, 858	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	109, 040	21, 545	130, 585	0	130, 585	76.97
0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	575, 649	2, 115, 706	2, 691, 355	0	2, 691, 355	90.00
91. 00 09100 EMERGENCY	1, 721, 381	395, 171			2, 116, 552	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	(01.42)	170 / 00	0(1.04)		0/1 0/4	101 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	681, 436	179, 608	861, 044	0	861, 044	101.00
113. 00 11300 I NTEREST EXPENSE		2, 177	2, 177	0	2, 177	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	24, 389, 151	34, 907, 991	59, 297, 142		59, 426, 645	
NONREI MBURSABLE COST CENTERS	1					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	59,686	28, 758			88, 444 11, 814, 006	190.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	8, 576, 910	3, 237, 096 0	11, 814, 006	1		192.00
192. 02 19202 WEST CLINIC	0	0		0		192.02
192. 03 19203 DI ABETES CENTER	80, 467	6, 721	87, 188		87, 188	192.03
193. 00 19300 NONPALD WORKERS	6	0		-		193.00
193. 01 19301 ADULT/CHI LD CARE 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG	530, 825	76, 419 0	607, 244	-129, 503	477, 741 0	193.01
193. 03 19302 PHISICIAN OFFICE BUILDING 193. 03 19303 OPTI FAST/FOUNDATI ON	0	901, 902	901, 902	, i	901, 902	
194. 00 07950 PARTNERSHI P HFC	23, 520	5, 594	29, 114		29, 114	194.00
194. 01 07951 TRAFALGAR CLINIC	0	0	(0		194.01
194. 02 07952 EDI NBURGH	0	10 000				194.02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C TRAI NERS	89, 628	48, 000 12, 978			48, 000 102, 606	194. 03 194. 04
200.00 TOTAL (SUM OF LINES 118-199)	33, 750, 187	39, 225, 459				•
			•			•

	Financial Systems	JOHNSON MEMORI			of Form CMS-2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-000	From 01/01/2015	Worksheet A
				To 12/31/2015	Date/Time Prepared: 1/16/2018 2:52 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8) F 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS		1 000 004		
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - TOWER	83, 182 0	1, 829, 904 86, 509		1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT - TOWER	0	2, 703, 810		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-138, 942	7, 315, 633		4.00
4.01	00401 COMMUNI CATI ONS	-17, 193	456, 822		4. 01
4.02	00402 DATA PROCESSING	0	1, 424, 811		4.02
4.03 4.04	00403 MATERI ALS MANAGEMENT 00404 ADMI TTI NG	0	276, 898 600, 254		4. 03 4. 04
4.05	00405 PATI ENT ACCOUNTI NG	-9,059	1, 475, 143		4.05
5.00	00500 ADMI NI STRATI VE & GENERAL	-2, 611, 843	3, 640, 989		5.00
7.00	00700 OPERATION OF PLANT	-42, 583	2, 544, 314		7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE	0	190, 816		8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	-2, 849	753, 732 411, 495		9.00
11.00	01100 CAFETERI A	-271, 153	374, 150		11.00
13.00	01300 NURSING ADMINISTRATION	-30, 218	1, 468, 082		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	182, 022		14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	-6, 428 -28, 843	3, 872, 285 693, 787		15.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	-20, 043	093, 707		10.00
30.00	03000 ADULTS & PEDIATRI CS	-784, 290	2, 732, 885		30.00
31.00	03100 I NTENSI VE CARE UNI T	0	1, 192, 461		31.00
41.00	04100 SUBPROVIDER - IRF	0	724, 585		41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	202, 175		43.00
50.00	05000 OPERATI NG ROOM	-34,027	2, 430, 500		50.00
53.00	05300 ANESTHESI OLOGY	0	20, 563		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-3, 178	2, 893, 897		54.00
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0 -7,000	3, 149, 005 992, 332		60. 00 65. 00
66.00	06600 PHYSI CAL THERAPY	000	735, 512		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	210, 155		67.00
68.00	06800 SPEECH PATHOLOGY	0	127, 852		68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	-51, 580 0	647, 193 54, 445		69.00 70.00
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 622, 765		70.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 451, 289		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020 ONCOLOGY	0	179, 858		76.00
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	130, 585		76. 97
90.00		-172,037	2, 519, 318		90.00
91.00	09100 EMERGENCY	-133, 448	1, 983, 104		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
101.00	OTHER REIMBURSABLE COST CENTERS	0	861, 044		101.00
	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE	-2, 177	0		113.00
118.00		-4, 263, 666	55, 162, 979		118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	88, 444		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	11, 814, 006		192.00
	19201 SOUTH CLINIC	0	0		192.01
	19202 WEST CLINIC	0	0		192. 02 192. 03
	19203 DI ABETES CENTER 19300 NONPAI D WORKERS	0	87, 188 0		192.03
	19301 ADULT/CHI LD CARE	0	477, 741		193.00
193.02	19302 PHYSICIAN OFFICE BUILDING	0	0		193. 02
	19303 OPTI FAST/FOUNDATI ON	0	901, 902		193.03
	07950 PARTNERSHI P HFC 07951 TRAFALGAR CLI NI C	0	29, 114 0		194. 00 194. 01
	07951 TRAFALGAR CLINIC 07952 EDI NBURGH	0	0		194.01
194.03	07953 JAI L	0	48, 000		194.02
	07954 ATHLETIC TRAINERS	0	102, 606		194.04
200.00	TOTAL (SUM OF LINES 118-199)	-4, 263, 666	68, 711, 980		200.00

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider (CCN: 15-0001	Peri od:	Worksheet A-	6
						From 01/01/2015 To 12/31/2015	Date/Time Pr 1/16/2018 2:	epared: 52 pm
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A – CAFETERIA RECLASS							
1.00	CAFETERI A	11.00	455, 969	189, 334				1.00
	TOTALS	T	455, 969	189, 334				
	B - CHILD CARE RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	113, 345	16, 158				1.00
	TOTALS		113, 345	16, 158				
	C - NURSERY RECLASS							
1.00	NURSERY	43.00	176, 154	26, 021				1.00
	TOTALS		176, 154	26, 021				
	D - IMPLANTABLE DEVICE RECLAS	S						
1.00	IMPL. DEV. CHARGED TO	72.00	0	1, 451, 289				1.00
	PATI ENTS							
	TOTALS		0	1, 451, 289				
500.00	Grand Total: Increases		745, 468	1, 682, 802	1			500.00

Heal th	Financial Systems		JOHNSON MEMORIA	L HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SIFICATIONS			Provider C	CN: 15-0001	Peri od:	Worksheet A-	6
						From 01/01/2015 To 12/31/2015	Date/Time Pr 1/16/2018 2:	epared: 52 pm
		Decreases	-					
	Cost Center	Line #	Salary	0ther	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - CAFETERIA RECLASS							
1.00	DI ETARY	10.00	455, 969	189, 334		0		1.00
	TOTALS		455, 969	189, 334				
	B - CHILD CARE RECLASS							
1.00	ADULT/CHILD CARE	193.01	113, 345	16, 158		0		1.00
	TOTALS		113, 345	16, 158				
	C - NURSERY RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	176, 154	26, 021		0		1.00
	TOTALS		176, 154	26, 021				
	D - IMPLANTABLE DEVICE RECLAS	S						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 451, 289		0		1.00
	PATI ENT							
	TOTALS		0	1, 451, 289				
500.00	Grand Total: Decreases		745, 468	1, 682, 802				500.00

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
RECONO	RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2015 To 12/31/2015		pared:
				Acqui si ti ons	5		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	3, 141, 963	1, 764, 926		0 1, 764, 926		1.00
2.00	Land Improvements	1, 603, 865	19, 836		0 19, 836	160, 516	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	68, 738, 750	9, 114, 129	-2, 622, 22	6, 491, 905	8, 286, 524	4.00
5.00	Fixed Equipment	11, 690, 283	422, 876	710, 93	1, 133, 810	0	5.00
6.00	Movable Equipment	36, 227, 029	0	1, 911, 29	1, 911, 290	298, 289	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	121, 401, 890	11, 321, 767		0 11, 321, 767	8, 908, 889	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	121, 401, 890	11, 321, 767		0 11, 321, 767	8, 908, 889	10.00
		Ending Balance	Fully				
		J	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	4, 743, 329	0				1.00
2.00	Land Improvements	1, 463, 185	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	66, 944, 131	0				4.00
5.00	Fixed Equipment	12, 824, 093	0				5.00
6.00	Movable Equipment	37, 840, 030	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	123, 814, 768	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	123, 814, 768	0				10.00

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0001	Period: From 01/01/2015	Worksheet A-7 Part II	
					To 12/31/2015		
			SL	JMMARY OF CAP	TAL	2 pm	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK		N 2, LINES 1 a	nd 2		I	
1.00	CAP REL COSTS-BLDG & FIXT	1, 746, 722	0		0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	86, 509	0		0 0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	2, 703, 810	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	4, 537, 041	0		0 0	0	3.00
		SUMMARY OF	F CAPITAL				
	Cost Center Description	Other i	Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	0 /				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 746, 722				1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	86, 509				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 703, 810				2.00
3.00	Total (sum of lines 1-2)	0	4, 537, 041				3.00

Heal th	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F		Date/Time Prep 1/16/2018 2:52	
		COME	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed 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 C						
1.00	CAP REL COSTS-BLDG & FIXT	85, 974, 738	C	85, 974, 738			1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0) (0. 000000		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	37, 840, 030	C	37, 840, 030	0. 305618	0	2.00
3.00	Total (sum of lines 1-2)	123, 814, 768	C	123, 814, 768	1. 000000	0	3.00
			TION OF OTHER (F CAPI TAL	
	Cost Center Description	Taxes	Other Capital-Relate d 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 C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	C) (1, 829, 904	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	C		86, 509	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	C C		2, 703, 810	0	2.00
3.00	Total (sum of lines 1-2)	0	c c		4, 620, 223	0	3.00
			SI	JMMARY OF CAPI	AL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	•		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	C) (0 0	1, 829, 904	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TOWER	0	C	0 0	0 0	86, 509	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	C	0 0	0 0	2, 703, 810	2.00
3.00	Total (sum of lines 1-2)	0	c) (0 0	4, 620, 223	3.00

JUSTI	MENTS TO EXPENSES			Provider CCN: 15-0001	Period: From 01/01/2015	Worksheet A-8	
					To 12/31/2015		
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1. C
01	Investment income - CAP REL COSTS-BLDG & FIXT - TOWER (chapter 2)			CAP REL COSTS-BLDG & FIXT - TOWER	1.01	0	1. C
00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. (
00	Investment income - other (chapter 2)		0		0.00	0	3. (
00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.0
00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. C
00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. (
00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.0
00	Television and radio service (chapter 21)		0		0.00	0	8. 0
00). 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 019, 095		0.00	0	
	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.
2. 00	(chapter 23) Related organization	A-8-1	0			0	12.
	transactions (chapter 10) Laundry and linen service		0		0.00		
	Cafeteria-employees and guests Rental of quarters to employee		0 0		0.00 0.00		
6. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16.
. 00	patients Sale of drugs to other than		0		0.00	0	17.
3. 00	patients Sale of medical records and		0		0.00	0	18.
. 00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.
	books, etc.) Vending machines		0		0.00		
. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21.
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.
. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.
. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT -	1.01	0	26.
. 00	COSTS-BLDG & FIXT - TOWER Depreciation - CAP REL		0	TOWER CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.
. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29. 30.
	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.

	Financial Systems		JOHNSON MEMORI			u of Form CMS-2	
ADJUSI	MENTS TO EXPENSES				Period: From 01/01/2015	Worksheet A-8	
					To 12/31/2015		
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
					1		
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
31 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	4.00		31.0
01.00	pathology costs in excess of		0		00.00		01.0
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.0
~~ ~~	Depreciation and Interest		170.007				
33.00	JMH PAIN CARE CENTER REV	В	-172, 037	CLINIC	90.00	0	33.0
34.00	JMH NUTR SVCS DI SCOUNTS	В	80	DI ETARY	10.00	0	34.0
01.00	OPERATING FU	U	00		10.00		01.0
35.00	JMH PURCHASES DI SCOUNTS	В	-4, 385	ADMINISTRATIVE & GENERAL	5.00	0	35.0
	OPERATING FU						
36.00	JMH SALE OF FILM	В		RADI OLOGY-DI AGNOSTI C	54.00		
37.00	JMH CAFETERIA REV OPERATING	В	-271, 153	CAFETERI A	11.00	0	37.0
38.00	JMH CATERING REV OPERATING	В	-2 929	DI ETARY	10.00	0	38.0
00.00	FUND	, , , , , , , , , , , , , , , , , , ,	2,727		10.00		
39.00	JMH MISC PHARM REVENUE	В	-6, 428	PHARMACY	15.00	0	39.0
	OPERATING FUN						
40.00	JMH RENT OF SPACE	В		OPERATION OF PLANT	7.00		
41.00	JMH MEDICAL RECORD FEES OPERATING FU	В	-28, 843	MEDICAL RECORDS & LIBRARY	16.00	0	41.0
42.00	JMH GEN ACCOUNTING REV	В	-7.680	ADMI NI STRATI VE & GENERAL	5.00	0	42.0
	OPERATING FUN	_	.,			-	
43.00	JMH RETURNED CHECK FEES	В	-350	ADMINISTRATIVE & GENERAL	5.00	0	43.0
	OPERATING FU	_				_	
44.00	JMH EDUCATION PROGRAMS OPERATING FUN	В	-175	NURSING ADMINISTRATION	13.00	0	44.0
44.01	JMH BILLING SERVICES REV	В	_9 059	PATIENT ACCOUNTING	4.05	0	44.0
11.01	OPERATING F	U U	,,00,		1.00		
44.02	JMH MISC REV GRANT	В	-1, 912	ADMINISTRATIVE & GENERAL	5.00	0	44.0
45.00		A		CAP REL COSTS-BLDG & FIXT	1.00		
	MED STAFF OTHER EXP	A		ADMI NI STRATI VE & GENERAL	5.00		
	CABLE SERVICES	A		OPERATION OF PLANT	7.00		
45.03	TELEPHONE SERVICES	A		CAP REL COSTS-BLDG & FIXT	1.00		
45.04	TELEPHONE SERVICES	A		ADMINISTRATIVE & GENERAL	5.00		
45.05	COMMUNI CATI ONS	A			4.01	0	
	ADVERTISING EXP-A&G	A		ADMI NI STRATI VE & GENERAL	5.00		
45.08	ADVERTISING EXP -NURSING ADMIN			NURSING ADMINISTRATION	13.00	0	
45.13	DAYCARE	В		EMPLOYEE BENEFITS DEPARTMENT		0	
45.14	LOBBYING EXPENSE-AHA	A		ADMI NI STRATI VE & GENERAL	5.00	0	
45.15	LOBBYING EXPENSE-IHHA	A		ADMI NI STRATI VE & GENERAL	5.00		
45.16	PROF - BUILDING	A		OPERATION OF PLANT	7.00		
45.17	PROF - BUILDING	A		EMPLOYEE BENEFITS DEPARTMEN			
45.19	INTEREST INCOME	B		INTEREST EXPENSE	113.00		
46.00 50.00	HOSPITAL ASSESSMENT FEE TOTAL (sum of lines 1 thru 49)	A	-2, 317, 798 -4, 263, 666	ADMI NI STRATI VE & GENERAL	5.00	0	46. 0 50. 0
50.00	(Transfer to Worksheet A,		-4, 203, 000				50.0
	column 6, line 200.)						

 column 6, line 200.)
 |

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

(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.

Heal th	Financial Syste	ms	JOHNSON MEMOR	RIAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSICI	AN ADJUSTMENT		Provider (CN: 15-0001	Peri od:	Worksheet A-8	3-2
						From 01/01/2015 To 12/31/2015		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component	I I I I I I I I I I I I I I I I I I I	ider Component	
		i dontri i i di	itolianoi a tron	oomportonit	oomponone		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	5, 750	5, 750			0	1.00
2.00		SUBPROVIDER - IRF	105, 050				-	2.00
2.00		OPERATING ROOM	34, 027	34, 027		225, 300		2.00
4.00		RADI OLOGY-DI AGNOSTI C	34,027	34, 027				4.00
5.00		LABORATORY	110,004	0	110, 00			5.00
6.00		RESPI RATORY THERAPY	7,000	7,000		,		6.00
7.00		ELECTROCARDI OLOGY	51, 580			225, 300		7.00
8.00		EMERGENCY	138, 518					8.00
9.00		ADULTS & PEDIATRICS	784, 290					9.00
10.00	0.00		0	0		0 0	-	10.00
200.00			1, 239, 219	1, 019, 095	220, 12	1	2, 648	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	(0 0	0	1.00
2.00	41.00	SUBPROVIDER – IRF	107, 776	5, 389	(0 0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	(0 0	0	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	(0 0	0	4.00
5.00	60, 00	LABORATORY	170, 600	8, 530	(o l	0	5.00
6.00		RESPI RATORY THERAPY	0	0		0	0	6.00
7.00		ELECTROCARDI OLOGY	0	0			0	7.00
8.00		EMERGENCY	8, 449	-			0	8.00
9.00		ADULTS & PEDIATRICS	0, 117	0			0	9,00
10.00	0.00		0	0			0	10.00
200.00	0.00		286, 825	14, 341			0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSL A LINE #	I denti fi er	Component	Limit	Di sal l owance	Aujustilient		
		Identifier	Share of col.		DISALLOWANCE			
			14					
	1.00	2.00	14	16.00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	15.00					1.00
2.00		SUBPROVIDER - IRF	0	-				2.00
2.00		OPERATING ROOM	0					2.00
				•				
4.00		RADI OLOGY-DI AGNOSTI C	0	0		0,000		4.00
5.00		LABORATORY	0	1707000		-		5.00
6.00		RESPI RATORY THERAPY	0	0		.,		6.00
7.00		ELECTROCARDI OLOGY	0	-	(7.00
8.00		EMERGENCY	0	8, 449				8.00
9.00		ADULTS & PEDIATRICS	0	0	(9.00
10.00	0.00		0	0	(0 0		10.00
200.00			0	286, 825	(1, 019, 095		200.00

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B Part I Date/Time Pre	pared:
		CAPI	TAL RELATED CO	OSTS	1/16/2018 2:5	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT TOWER 2.00 00200 CAP REL COSTS-BLDG & FIXT TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00401 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNI CATI ONS 4.02 00402 DATA PROCESSI NG 4.03 00403 MATERI ALS MANAGEMENT 4.04 00404 ADMI TTI NG 5.00 004005 PATI ENT ACCOUNTI NG 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE	$\begin{array}{c} 1, 829, 904\\ 86, 509\\ 2, 703, 810\\ 7, 315, 633\\ 456, 822\\ 1, 424, 811\\ 276, 898\\ 600, 254\\ 1, 475, 143\\ 3, 640, 989\\ 2, 544, 314\\ 190, 816\end{array}$	1, 829, 904 0 19, 528 2, 572 40, 968 25, 039 14, 653 43, 520 62, 341 163, 347 15, 733	0 0 12, 498 0	2, 703, 810 1, 910 0 1, 372, 928 5, 852 0 10, 139 26, 108 30, 103 4, 298	7, 337, 071 43, 359 166, 832 50, 521 125, 268 186, 735 408, 776 133, 601 26, 356	4.02 4.03 4.04 4.05 5.00 7.00 8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	753, 732 411, 495 374, 150 1, 468, 082 182, 022 3, 872, 285 693, 787	12, 218 25, 634 27, 296 64, 573 11, 119 13, 390 25, 386	937 554 0 0 0 0 0 0	14, 568 0 31, 974 30, 057 4, 798 4, 669	140, 708 64, 323 100, 180 280, 031 16, 087 99, 560 104, 887	10.00 11.00 13.00 14.00 15.00 16.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	2, 732, 885 1, 192, 461 724, 585 202, 175	180, 473 51, 609 44, 259 4, 090	19, 566 8, 861 7, 599 0	24, 315 14, 173	613, 954 237, 594 128, 803 38, 702	31.00 41.00
ANGLEART SLEVTCL COST CLINTERS 50. 00 OPERATI NG ROOM 53.00 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY 54.00 RADI OLOGY - DI AGNOSTI C 60. 00 06000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 66.00 06600 SPEECH PATHOLOGY 67. 00 06700 OCCUPATI ONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 0.00 00000 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 70.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 73.00 03020 ONCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVICE COST CENTERS	$\begin{array}{c} 2,430,500\\ 20,563\\ 2,893,897\\ 3,149,005\\ 992,332\\ 735,512\\ 210,155\\ 127,852\\ 647,193\\ 54,445\\ 1,622,765\\ 1,451,289\\ 0\\ 179,858\\ 130,585\end{array}$	299, 476 2, 578 108, 191 52, 675 22, 081 41, 478 8, 737 543 7, 068 1, 191 0 0 0 45, 804 16, 433	0 12, 062 6, 924 1, 203 0 93 99 204 204 0 0 0	13, 415 287, 598 126, 017 20, 883 9, 280 1, 953 324 32, 410 1, 432 10, 522 0 0 0 0		$\begin{array}{c} 53.\ 00\\ 54.\ 00\\ 60.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 76.\ 00\\ \end{array}$
90. 00 009000 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	2, 519, 318 1, 983, 104	75, 365 65, 012			126, 474 378, 199	
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	861, 044	8, 540	0	733	149, 716	101.00
113. 00 11300 INTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	55, 162, 979	1, 602, 920	84, 600	2, 628, 196	5, 305, 273	113. 00 118. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLI NI C	88, 444 11, 814, 006 0	8, 488 169, 662 0	0	73, 172 0	1, 884, 423 0	192. 00 192. 01
192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS 193. 01 19301 ADULT/CHI LD CARE 193. 02 19302 PHYSI CI AN OFFICE BUI LDI NG 193. 03 0PTI FAST/FOUNDATI ON	0 87, 188 0 477, 741 0 901, 902	0 2, 631 0 31, 622 0 0	0 452 0 0 0 0 0	287	17, 679 0 91, 723 0 0	192. 02 192. 03 193. 00 193. 01 193. 02 193. 03
194.00 07950 PARTNERSHIP HFC 194.01 07951 TRAFALGAR CLINIC 194.02 07952 EDI NBURGH 194.03 07953 JAIL 194.04 07954 ATHLETIC 194.04 07954 Cross Foot Adj ustments	29, 114 0 0 48, 000 102, 606	14, 581 0 0 0 0	0 0 0 0 0	0 0 0 0 0	0 0 0	194. 00 194. 01 194. 02 194. 03 194. 04 200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	68, 711, 980	0 1, 829, 904	0 86, 509	0 2, 703, 810		201.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2015	Worksheet B Part I	
			Te		Date/Time Pre	
Cost Center Description	COMMUNI CATI ONS	DATA PROCESSI NG	MATERI ALS MANAGEMENT	ADMI TTI NG	1/16/2018 2:5 PATIENT ACCOUNTING	
	4.01	4. 02	4. 03	4.04	4. 05	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER						1.00 1.01
2.00 00200 CAP REL COSTS-BEDG & TTXT - TOWER						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01 00401 COMMUNI CATI ONS	502, 753					4.01
4. 02 00402 DATA PROCESSING	59, 533	3,065,072				4.02
4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG	10, 754 9, 218	49, 839 0	418, 903 1, 780	753, 015		4.03 4.04
4. 05 00405 PATIENT ACCOUNTING	31, 878	471, 685		/53, 015	2, 221, 663	4.04
5. 00 00500 ADMI NI STRATI VE & GENERAL	28, 806	250, 973		0	0	5.00
7.00 00700 OPERATION OF PLANT	14, 979	39, 159	108	0	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	1, 920	7, 120		0	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	5, 377 9, 602	0 129, 936	83 12, 554	0	0 0	9.00 10.00
11. 00 01100 CAFETERIA	9,002	129, 930	12, 554	0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	16, 131	0	4, 280	0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	3, 356	0	0	14.00
	6, 529	42, 719		0	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	15, 747	192, 234	165	0	0	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	38, 023	441, 427	10, 899	45, 251	133, 499	30.00
31. 00 03100 I NTENSI VE CARE UNI T	10, 754	0		6, 692	19, 742	
41. 00 04100 SUBPROVI DER - I RF	6, 913	110, 357	977	6, 422	18, 945	•
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	2, 459	7, 256	43.00
50. 00 05000 OPERATING ROOM	31, 110	283, 012	21, 670	123, 204	363, 476	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	90	11, 010	32, 482	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 972	288, 352		153, 801	453, 865	•
60. 00 06000 LABORATORY	26, 117	110.257	59, 925	110, 867	327, 080	•
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	6, 913 8, 066	119, 257 42, 719	6, 181 1, 334	21, 538 13, 665	63, 541 40, 316	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 536	8, 900		7, 458	22,004	67.00
68.00 06800 SPEECH PATHOLOGY	1, 536	5, 340	6	2, 632	7, 766	68.00
69. 00 06900 ELECTROCARDI OLOGY	15, 363	0	2, 382	20, 762	61, 253	•
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	768 0	0	72 183, 067	656 23, 548	1, 934 69, 470	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19, 010	56, 082	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	47, 270	139, 456	•
76.00 03020 ONCOLOGY	14, 211	26, 699		2, 759	8, 140	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	546	2, 004	5, 912	76.97
90. 00 09000 CLINIC	6, 913	131, 716	31, 533	48, 560	143, 262	90.00
91. 00 09100 EMERGENCY	21, 508	0	5, 639	76, 230	224, 892	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	8,066	0	863	7, 217	21 290	101.00
SPECIAL PURPOSE COST CENTERS	0,000	0	003	7,217	21,270	101.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	428, 243	2, 641, 444	376, 151	753, 015	2, 221, 663	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 761	71, 198	786	0	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	58, 763	352, 430		0		192.00
192. 01 19201 SOUTH CLINIC	0	0	0	0		192. 01
192. 02 19202 WEST CLINIC	0	0	0	0		192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	1, 152	0	18 0	0		192. 03 193. 00
193. 01 19301 ADULT/CHI LD CARE	5, 761	0	4, 387	0		193.00
193. 02 19302 PHYSICIAN OFFICE BUILDING	0	0	0	0	0	193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193.03
194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C	3, 073	0	159	0		194. 00 194. 01
194. 02 07952 EDI NBURGH	0	0	0	0		194.01
194. 03 07953 JAI L	0	0	0	0	0	194. 03
194. 04 07954 ATHLETIC TRAINERS	0	0	9	0	0	194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers		0		0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	502, 753	3, 065, 072	418, 903	753, 015	2, 221, 663	
		· •				•

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	JOHNSON MEMORI	AL HOSPITAL Provider C	CN: 15-0001 P	In Lie eriod:	u of Form CMS- Worksheet B	2552-10
0001 //					rom 01/01/2015	Part I Date/Time Pre 1/16/2018 2:5	
	Cost Center Description		ADMI NI STRATI VE & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	2 pm
	GENERAL SERVICE COST CENTERS	4A. 05	5.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG						4.01
4.02 4.03	00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT						4.02 4.03
4.04	00404 ADMI TTI NG						4.04
4.05	00405 PATIENT ACCOUNTING						4.05
5.00	00500 ADMINISTRATIVE & GENERAL	4, 423, 527	4, 423, 527				5.00
7.00	00700 OPERATION OF PLANT	2, 938, 109	202, 162				7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	246, 280 915, 468	16, 946 62, 991		297, 113 55, 434	1, 060, 210	8.00 9.00
10.00	01000 DI ETARY	668, 666	46, 009			19,006	1
11.00	01100 CAFETERI A	501, 626	34, 515		0	20, 238	1
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 865, 071	128, 330			47, 875	1
14.00	01400 CENTRAL SERVICES & SUPPLY	242, 641	16, 695			8, 244	1
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	4, 039, 281 1, 036, 875	277, 931 71, 344			9, 927 18, 821	1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,030,075	71, 344	54,078	9	10, 021	10.00
30.00	03000 ADULTS & PEDIATRICS	4, 352, 082	299, 454	388, 724	71, 716	133, 805	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 555, 281	107, 014		20, 893	38, 263	1
41.00	04100 SUBPROVIDER - IRF	1,063,033	73, 144			32, 815	1
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	254, 682	17, 524	8, 810	0	3, 033	43.00
50.00	05000 OPERATI NG ROOM	4, 290, 500	295, 216	645, 047	62, 341	222, 035	50.00
53.00	05300 ANESTHESI OLOGY	80, 138	5, 514			1, 912	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 665, 149	320, 995	233, 034	18, 031	80, 214	54.00
60.00	06000 LABORATORY	4, 165, 661	286, 627			39, 054	1
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 441, 494	99, 185			16, 371	1
66.00 67.00	06700 OCCUPATIONAL THERAPY	1, 043, 996 306, 912	71, 834 21, 118			30, 752 6, 478	
68.00	06800 SPEECH PATHOLOGY	172, 818	11, 891			403	1
69.00	06900 ELECTROCARDI OLOGY	872, 566	60, 039	15, 224	1, 478	5, 240	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	71, 076	4, 891			883	1
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	1,909,372	131, 378			0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 526, 381 186, 726	105, 026 12, 848			0	
	03020 ONCOLOGY	313, 761	21, 589			33, 960	1
76.97	07697 CARDI AC REHABI LI TATI ON	181, 524	12, 490	35, 395	0	12, 184	76.97
00.00	OUTPATIENT SERVICE COST CENTERS	0.007.470	040.400	1 (0 . 0 0 0	0.00(FF 07/	
	09000 CLINIC 09100 EMERGENCY	3, 097, 178 2, 800, 441	213, 108 192, 690				90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,000,441	172,070	140, 027	42,033	40, 200	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1,057,469	72, 761	18, 395	0	6, 332	101.00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00		52, 285, 784	3, 293, 259	2, 651, 366	290, 736	891, 921	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	191, 402	13, 170				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 SOUTH CLINI C	14, 389, 849	990, 152			125, 790	1
	19201 SOUTH CLINIC 19202 WEST CLINIC	0	0		0		192. 01 192. 02
	19203 DI ABETES CENTER	109, 407	7, 528	-	0		192.02
	19300 NONPAI D WORKERS	0	0	0	0		193.00
	19301 ADULT/CHI LD CARE	611, 234	42, 057	68, 112	0		193. 01
	19302 PHYSI CLAN OFFICE BUILDING	001.002	() 40 057	0	0		193.02
	19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI P HFC	901, 902 52, 095	62, 057 3, 585		0		193. 03 194. 00
	07951 TRAFALGAR CLINIC	0	0,000		0		194.00
	07952 EDI NBURGH	0	0	-	0		194.02
	07953 JAI L	48, 000	3, 303		0		194. 03
	07954 ATHLETIC TRAINERS	122, 307	8, 416	0	0	0	194.04
200.00 201.00		0	0		0	n	200. 00 201. 00
201.00		68, 711, 980	4, 423, 527	-	297, 113		

Health F	Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS		Provider C		eriod: ^om 01/01/2015	Worksheet B Part I	
				To			
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS						
1.01 C 2.00 C	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-MVBLE EQUIP						1.00 1.01 2.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00 4.01
4.02 0	DO402 DATA PROCESSI NG						4.02
	DO4O3 MATERIALS MANAGEMENT DO4O4 ADMITTING						4.03 4.04
4.05 C	DO405 PATIENT ACCOUNTING						4.05
	DO500 ADMINISTRATIVE & GENERAL DO700 OPERATION OF PLANT						5.00 7.00
8.00 0	DO800 LAUNDRY & LINEN SERVICE						8.00
	DO900 HOUSEKEEPI NG D1000 DI ETARY	792, 858					9.00 10.00
	D1100 CAFETERI A	192,050	615, 173	3			11.00
	01300 NURSI NG ADMI NI STRATI ON	0	18, 209				13.00
	D1400 CENTRAL SERVI CES & SUPPLY D1500 PHARMACY	0	3, 342 9, 867		294, 871 0	4, 365, 846	14.00 15.00
	D1600 MEDI CAL RECORDS & LI BRARY	0	20, 778		0	4, 303, 040	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS	E 40, 200	(0.075		ol	0	20.00
	D3100 INTENSIVE CARE UNIT	548, 389 107, 516	69, 075 28, 777		0	0	30.00 31.00
41.00 0	04100 SUBPROVIDER - IRF	136, 953	16, 860	175, 159	0	0	41.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	4, 952	2 51, 445	0	0	43.00
	D5000 OPERATING ROOM	0	47, 096	489, 286	0	0	50.00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	51, 174 49, 753		0	0	54.00 60.00
65. 00 C	06500 RESPI RATORY THERAPY	0	22, 878		Ō	0	65.00
	06600 PHYSI CAL THERAPY	0	17, 954		0	0	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	4, 816 2, 689		0	0	67.00 68.00
69. 00 C	D6900 ELECTROCARDI OLOGY	0	8, 875	5 0	О	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 423		0 294, 871	0	70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	4, 365, 846	1
	03020 ONCOLOGY 07697 CARDI AC REHABI LI TATI ON	0	4, 640 2, 959		0	0	
C	DUTPATIENT SERVICE COST CENTERS		· · · · ·		1		
	09000 CLINIC 09100 EMERGENCY	0	21, 207 44, 862		0 0	0	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	, S	11,002	100,070	0	0	92.00
	DTHER REIMBURSABLE COST CENTERS	0	17, 260	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	17,200		<u> </u>	0	101.00
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	792, 858	469, 446	2, 198, 570	294, 871	4, 365, 846	113. 00 118. 00
190.001	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 843		0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 SOUTH CLINI C	0	106, 930		0		192. 00 192. 01
	19202 WEST CLINIC	0	0		0		192.01
192.031	19203 DI ABETES CENTER	0	1, 997	0	О	0	192. 03
	19300 NONPALD WORKERS 19301 ADULT/CHILD CARE	0	0 26, 140		0		193. 00 193. 01
193.021	19302 PHYSICIAN OFFICE BUILDING	0	20, 140		0	0	193. 02
	19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193.03
	07950 PARTNERSHI PHFC 07951 TRAFALGAR CLI NI C	0	3, 785 (0		194. 00 194. 01
194.020	07952 EDI NBURGH	0	C	o o	Ö	0	194. 02
	07953 JAI L 07954 ATHLETI C TRAI NERS	0	0 4, 032		0		194. 03 194. 04
200.00	Cross Foot Adjustments		4, 032		0	0	200.00
201.00	Negative Cost Centers	0			0		201.00
202.00	TOTAL (sum lines 118-201)	792, 858	615, 173	2, 198, 570	294, 871	4, 365, 846	1202. UU

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0001	Peri od:	Worksheet B
				From 01/01/2015 To 12/31/2015	
					1/16/2018 2:52 pm
Cost Center Description	MEDI CAL RECORDS &	Subtotal	Intern &	Total	
	LIBRARY		Residents Cos & Post		
			Stepdown		
			Adjustments		
GENERAL SERVICE COST CENTERS	16.00	24.00	25.00	26.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER					1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01 00401 COMMUNI CATI ONS					4.01
4. 02 00402 DATA PROCESSING 4. 03 00403 MATERIALS MANAGEMENT					4.02
4. 04 00404 ADMI TTI NG					4.03
4.05 00405 PATIENT ACCOUNTING					4.05
5. 00 00500 ADMI NI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG					8.00
10. 00 01000 DI ETARY					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 16. 00 01600 MEDI CAL RECORDS & LI BRARY	1, 202, 496				15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	1, 202, 490				10.00
30. 00 03000 ADULTS & PEDI ATRI CS	72, 254	6, 653, 132	2	0 6, 653, 132	30.00
31.00 03100 I NTENSI VE CARE UNI T	10, 685	2, 278, 561		0 2, 278, 561	31.00
41. 00 04100 SUBPROVI DER – I RF	10, 254	1, 614, 347		0 1, 614, 347	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 927	344, 373		0 344, 373	43.00
50. 00 05000 OPERATI NG ROOM	196, 725	6, 248, 246		0 6, 248, 246	50.00
53.00 05300 ANESTHESI OLOGY	17, 580	110, 698	8	0 110, 698	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	245, 707	5, 614, 304		0 5, 614, 304	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	177, 026 34, 390	4, 831, 579 1, 661, 878		0 4, 831, 579 0 1, 661, 878	
66. 00 06600 PHYSI CAL THERAPY	21, 820	1, 277, 047		0 1, 277, 047	
67. 00 06700 OCCUPATI ONAL THERAPY	11, 909	370, 051		0 370, 051	67.00
68.00 06800 SPEECH PATHOLOGY	4, 203	193, 174		0 193, 174	
69. 00 06900 ELECTROCARDI OLOGY	33, 152	996, 574		0 996, 574	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 047 37, 600	81, 885 2, 373, 221		0 81, 885 0 2, 373, 221	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	30, 353	1, 661, 760		0 1, 661, 760	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	75, 478	4, 640, 898		0 4, 640, 898	73.00
76. 00 03020 ONCOLOGY	4, 406	477, 014		0 477, 014	76.00
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	3, 200	247, 752	2	0 247, 752	76.97
90. 00 09000 CLINIC	77, 538	3, 629, 332		0 3, 629, 332	90.00
91. 00 09100 EMERGENCY	121, 719	3, 856, 652		0 3, 856, 652	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	11, 523	1, 183, 740	J	0 1, 183, 740	101.00
SPECIAL PURPOSE COST CENTERS	11, 525	1, 103, 740	/	0 1, 103, 740	101.00
113.00 11300 I NTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 202, 496	50, 346, 218	3	0 50, 346, 218	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	231, 990	J	0 231, 990	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	15, 984, 536		0 15, 984, 536	
192. 01 19201 SOUTH CLINIC	0	0		0 0	192.01
192. 02 19202 WEST CLINIC	0	0		0 0	192. 02
192. 03 19203 DI ABETES CENTER	0	126, 550		0 126, 550	192.03
193. 00 19300 NONPALD WORKERS 193. 01 19301 ADULT/CHI LD CARE	0	0 770, 988		0 0 0 770, 988	193. 00 193. 01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG	0	۰، ۱۵, ۶۵۵ ۱		0 0	193.01
193. 03 19303 OPTI FAST/FOUNDATI ON	0	963, 959		0 963, 959	193. 03
194. 00 07950 PARTNERSHI P HFC	0	101, 681		0 101, 681	194.00
194. 01 07951 TRAFALGAR CLI NI C 194. 02 07952 EDI NBURGH	0	0		0 0	194. 01 194. 02
194. 02 07952 EDI NBURGH 194. 03 07953 JAI L	0	51, 303		0 51, 303	
194. 04 07954 ATHLETI C TRAI NERS	0	134, 755		0 134, 755	
200.00 Cross Foot Adjustments		0		0 0	200.00
201.00 Negative Cost Centers	1 202 404	60 711 000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	201.00 202.00
202.00 TOTAL (sum lines 118-201)	1, 202, 496	68, 711, 980	1	0 68, 711, 980	J202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2015	Worksheet B Part II	
			T		Date/Time Pre 1/16/2018 2:5	pared: 2 pm
		CAP	ITAL RELATED CO	ISTS	1710/2010 2.0	
Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT -	MVBLE EQUIP	Subtotal	
	Assigned New		TOWER			
	Capital Related Costs					
	0	1.00	1. 01	2.00	2A	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	19, 528	0	1, 910	21, 438	2.00 4.00
4. 01 00401 COMMUNI CATI ONS	0	2, 572	0	0	2, 572	4.01
4. 02 00402 DATA PROCESSI NG 4. 03 00403 MATERI ALS MANAGEMENT	0	40, 968 25, 039		1, 372, 928 5, 852	1, 413, 896 30, 891	4.02 4.03
4. 04 00404 ADMI TTI NG	0	14, 653		0	16, 495	4.03
4. 05 00405 PATIENT ACCOUNTING	0	43, 520		10, 139	53, 659	4.05
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	0	62, 341 163, 347		26, 108 30, 103	88, 449 205, 948	5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	15, 733	0	4, 298	20, 031	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	12, 218 25, 634		2, 413 14, 568	15, 568 40, 756	9.00 10.00
11. 00 01100 CAFETERI A	0	27, 296	0	0	27, 296	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	64, 573 11, 119		31, 974 30, 057	96, 547 41, 176	13.00 14.00
15. 00 01500 PHARMACY	0	13, 390	0	4, 798	18, 188	
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	25, 386	0	4, 669	30, 055	16.00
30. 00 03000 ADULTS & PEDIATRICS	0	180, 473	19, 566	136, 105	336, 144	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			24, 315	84, 785	31.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0			14, 173 0	66, 031 4, 090	41.00 43.00
ANCI LLARY SERVI CE COST CENTERS	-					
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0			355, 895 13, 415	656, 173 15, 993	50.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	108, 191	12, 062	287, 598	407, 851	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	52, 675 22, 081	6, 924 1, 203	126, 017 20, 883	185, 616 44, 167	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	41, 478		9, 280	50, 758	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	8, 737 543		1, 953 324	10, 690 960	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	7, 068		324 32, 410	980 39, 577	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	1, 191		1, 432	2, 827	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10, 522 0	10, 522 0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	73.00
76. 00 03020 0NCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	0			2, 699 2, 087	48, 503 18, 520	76.00 76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0				89, 402 110, 869	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	03, 012	10, 800	54, 777	0	92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0	8, 540	0	733	0.272	101.00
SPECIAL PURPOSE COST CENTERS	0	0, 540	0	/ 33	7,273	101.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117)		1 (02 020	84.400	2 (20 10(4 015 714	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	1, 602, 920	84, 600	2, 628, 196	4, 315, 716	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			2, 155	12, 100	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLINI C	0	169, 662 0		73, 172 0	242, 834 0	192.00 192.01
192.02 19202 WEST CLINIC	0	0	0	0	0	192. 02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	0	2, 631	452 0	287		192. 03 193. 00
193. 01 19300 NONPALD WORKERS 193. 01 19301 ADULT/CHI LD CARE	0	31, 622		0		193.00
193. 02 19302 PHYSICIAN OFFICE BUILDING	0	0	0	0		193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	0	0 14, 581	0	0		193. 03 194. 00
194. 01 07951 TRAFALGAR CLINIC	0	0	0	0		194.00
194. 02 07952 EDI NBURGH	0	0	0	0	0	194. 02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C TRAI NERS	0	0	0	0		194. 03 194. 04
200.00 Cross Foot Adjustments				Ŭ	0	200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118-201)	0	0 1, 829, 904	0 86, 509	0 2, 703, 810	0 4, 620, 223	201.00
		,		_,0, 010	.,	

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2015	Worksheet B Part II	
			To		Date/Time Pre 1/16/2018 2:5	
Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	DATA PROCESSI NG	MATERIALS MANAGEMENT	ADMI TTI NG	
	4.00	4.01	4.02	4.03	4.04	
GENERAL SERVICE COST CENTERS						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.01 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNICATIONS	21, 438 127	2, 699				4.00 4.01
4. 02 00402 DATA PROCESSI NG	487	2, 099	1, 414, 706			4.01
4.03 00403 MATERIALS MANAGEMENT	148	58	23, 003	54, 100		4.03
4. 04 00404 ADMI TTI NG 4. 05 00405 PATI ENT ACCOUNTI NG	366 546	49 171	0 217, 710	230 331	17, 140 0	4.04 4.05
5. 00 00500 ADMINI STRATI VE & GENERAL	1, 194	155	115, 838	715	0	4.03 5.00
7.00 00700 OPERATION OF PLANT	390	80	18, 074	14	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	77	10	3, 286	5	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	411 188	29 52	0 59, 973	11 1, 621	0	9.00 10.00
11. 00 01100 CAFETERIA	293	0	0	0	0	11.00
13.00 01300 NURSING ADMINISTRATION	818	87	0	553	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	47 291	0 35	0 19, 717	433 0	0	14.00 15.00
15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY	306	35 85	88, 727	21	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS					-	
30. 00 03000 ADULTS & PEDIATRICS	1, 794	204	203, 744	1, 407	1, 028	
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	694 376	58 37	0 50, 936	420 126	152 146	
43. 00 04300 NURSERY	113	0	00, 700	0	56	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	1, 114 0	167 0	130, 626	2, 798 12	2, 799 250	50.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 259	107	133, 091	2, 138	3, 525	
60. 00 06000 LABORATORY	897	140	0	7, 739	2, 519	60.00
65. 00 06500 RESPIRATORY THERAPY	548	37	55, 044	798	489	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	443 135	43 8	19, 717 4, 108	172 0	311 169	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	78	8	2, 465	1	60	
69. 00 06900 ELECTROCARDI OLOGY	251	82	0	308	472	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	30 0	4	0	9 23, 646	15 535	70.00 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	23, 040	432	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1, 074	
76. 00 03020 ONCOLOGY 76. 97 07697 CARDIAC REHABILITATION	96 70	76 0	12, 323 0	90 70	63 46	
OUTPATIENT SERVICE COST CENTERS	/0	0	0	70	40	/0.9/
90. 00 09000 CLI NI C	370			4, 072		90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	1, 105	115	0	728	1, 732	91.00 92.00
OTHER REIMBURSABLE COST CENTERS				I		72.00
101.00 10100 HOME HEALTH AGENCY	437	43	0	111	164	101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	15, 499	2, 300	1, 219, 177	48, 579	17, 140	
NONREI MBURSABLE COST CENTERS					-	
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICLANS' PRIVATE OFFICES	38 5, 508	31 315	32, 862 162, 667	102 4, 829		190. 00 192. 00
192. 01 19201 SOUTH CLINIC	0	0	102,007	4, 027		192.00
192.02 19202 WEST CLINIC	0	0	0	0	0	192. 02
192. 03 19203 DI ABETES CENTER	52	6	0	2		192.03
193. 00 19300 NONPALD WORKERS 193. 01 19301 ADULT/CHI LD CARE	0 268	31	0	567		193. 00 193. 01
193. 02 19302 PHYSI CI AN OFFICE BUILDING	0	0	0	0		193.02
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193.03
194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C	15	16	0	20		194. 00 194. 01
194. 02 07952 EDI NBURGH	0	0	0	0		194.01
194. 03 07953 JAI L	0	0	0	Ō	0	194. 03
194. 04 07954 ATHLETIC TRAINERS	58	0	0	1	0	194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0	0	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	21, 438	2, 699	1, 414, 706	54, 100	17, 140	

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2015	Worksheet B Part II	
			T		Date/Time Pre	pared:
Cost Center Description	PATIENT	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	1/16/2018 2:5 HOUSEKEEPI NG	2 pm
	ACCOUNTI NG	& GENERAL	PLANT	LINEN SERVICE		
GENERAL SERVICE COST CENTERS	4.05	5.00	7.00	8.00	9.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER						1.01
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4. 01 00401 COMMUNI CATI ONS						4. 01
4. 02 00402 DATA PROCESSI NG						4.02
4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG						4.03 4.04
4. 05 00405 PATI ENT ACCOUNTING	272, 417					4.05
5.00 00500 ADMINI STRATI VE & GENERAL	0	206, 351				5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	0	9, 431 791		26, 724		7.00 8.00
9. 00 00900 HOUSEKEEPI NG	0	2, 939		4, 986	25, 905	•
10. 00 01000 DI ETARY	0	2, 146		356	464	
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	1, 610 5, 987		0	494 1, 170	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	779		0	201	14.00
15. 00 01500 PHARMACY	0	12, 966		0	243	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	3, 328	4, 073	0	460	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	16, 368	13, 970	28, 958	6, 450	3, 269	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 421	4, 992		1, 879	935	
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	2, 323 890	3, 412 818		971 0	802 74	41.00 43.00
ANCI LLARY SERVICE COST CENTERS	070	010	030	0	74	43.00
50. 00 05000 OPERATING ROOM	44, 565	13, 773		5, 607	5, 424	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 983 55, 670	257 14, 975		0 1, 622	47 1, 960	53.00 54.00
60. 00 06000 LABORATORY	40, 102	13, 372		0	954	60.00
65. 00 06500 RESPI RATORY THERAPY	7, 791	4, 627		0	400	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	4, 943 2, 698	3, 351 985		122 0	751 158	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	952	555		0	10	68.00
69. 00 06900 ELECTROCARDI OLOGY	7, 510	2, 801		133	128	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	237 8, 518	228 6, 129		0	22 0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 876	4, 900		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	17, 098	599	0	0	0	73.00
76. 00 03020 0NCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	998 725	1, 007 583		0	830 298	
OUTPATIENT SERVICE COST CENTERS	125	583	2,037	0	270	/0. 9/
90. 00 09000 CLI NI C	17, 565	9, 942		189	1, 365	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	27, 574	8, 989	10, 432	3, 835	1, 178	91.00 92.00
OTHER REI MBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY	2, 610	3, 394	1, 370	0	155	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	272, 417	153, 636	197, 515	26, 150	21, 792	118.00
NONREI MBURSABLE COST CENTERS			1 0/0			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	614 46, 179		0 574		190. 00 192. 00
192. 01 19201 SOUTH CLINIC	0	40, 177	0	0		192.00
192. 02 19202 WEST CLINIC	0	0	0	0		192. 02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	0	351	422	0		192. 03 193. 00
193. 01 19301 ADULT/CHI LD CARE	0	1, 962	-	0		193.00
193. 02 19302 PHYSICIAN OFFICE BUILDING	0	0	0	0		193. 02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	0	2, 895 167		0		193. 03 194. 00
194. 01 07951 TRAFALGAR CLINIC	0	0		0		194.00
194. 02 07952 EDI NBURGH	0	0	0	0	0	194. 02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C TRAI NERS	0	154 393		0		194. 03 194. 04
200.00 Cross Foot Adjustments		393		0	0	200.00
201.00 Negative Cost Centers	0	0	, v	0		201.00
202.00 TOTAL (sum lines 118-201)	272, 417	206, 351	233, 937	26, 724	25, 905	202.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lieu	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: com 01/01/2015 o 12/31/2015	Worksheet B Part II Date/Time Pre 1/16/2018 2:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS			1			1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT - TOWER 2.00 00200 CAP REL COSTS-BLDG & FIXT - TOWER 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNI CATIONS 4.02 00402 DATA PROCESSI NG 4.03 00403 MATERIALS MANAGEMENT						1.00 1.01 2.00 4.00 4.01 4.02 4.03
4. 04 00404 ADMI TTI NG 4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	109, 669					4.04 4.05 5.00 7.00 8.00 9.00 10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	000000000000000000000000000000000000000	34, 073 1, 009 185	2 116, 532 5 0	44, 605	F4 12F	11.00 13.00 14.00
15. 00 01500 PHARMACY 16. 00 01500 MEDI CAL RECORDS & LI BRARY HINDAL ENT. DOUTING CODY OF CONTENT	0	547 1, 151	-	0 0	54, 135 0	•
30. 00 03000 ADULTS & PEDIATRICS	75, 853	3, 826	38, 036	0	0	30.00
31.00 03100 I NTENSI VE CARE UNI T 41.00 04100 SUBPROVI DER - I RF 43.00 04300 NURSERY	14, 872 18, 944 0	1, 594 934 274	15, 847 9, 284	0 0 0	0 0 0	31.00 41.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0	2,609		0	0	50.00 53.00
54. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	2, 834		0	0	53.00
60. 00 06000 LABORATORY	0	2, 756		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 267		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	994		0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	267 149		0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	492		0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	79	0	0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0		44, 605	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0		-	0	0 54, 135	72.00
76. 00 03020 ONCOLOGY	0	257		0	54, 135 0	•
76. 97 07697 CARDI AC REHABI LI TATI ON	0	164		0	0	
OUTPATIENT SERVICE COST CENTERS	-	· ·	.r	-		
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	1, 175		0	0	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 485	24, 704	0	0	91.00
OTHER REIMBURSABLE COST CENTERS	0	956	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	109, 669	26, 004	116, 532	44, 605	54, 135	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	157		0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLINIC	0	5, 920	0	0		192. 00 192. 01
192. 02 19202 WEST CLINIC	0	0		0		192.01
192. 03 19203 DI ABETES CENTER	0	111	0	0		192.03
193.00 19300 NONPALD WORKERS	0	C	0 0	0		193.00
193. 01 19301 ADULT/CHI LD CARE	0	1, 448	8 0	0		193.01
193. 02 19302 PHYSICIAN OFFICE BUILDING 193. 03 19303 OPTIFAST/FOUNDATION	0			0		193. 02 193. 03
194. 00 07950 PARTNERSHI P HFC	0	210	0	0		194.00
194. 01 07951 TRAFALGAR CLINIC	0	C	0	0		194.01
194. 02 07952 EDI NBURGH	0		0	0		194.02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C TRAI NERS	0	223		0		194. 03 194. 04
200.00 Cross Foot Adjustments	0	223		0		200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118-201)	109, 669	34, 073	116, 532	44, 605	54, 135	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	JOHNSON MEMORIA		CN: 15 0001	Period:	u of Form CMS-2552-10 Worksheet B
ALLUCA	TION OF CAPITAL RELATED CUSTS		Provider C	CN: 15-0001	From 01/01/2015 To 12/31/2015	Part II
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments		171072018 2. 32 pill
	GENERAL SERVICE COST CENTERS	16.00	24.00	25.00	26.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - TOWER					1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4.01 4.02	00401 COMMUNI CATI ONS 00402 DATA PROCESSI NG					4. 01
4.03	00403 MATERIALS MANAGEMENT					4.03
4.04	00404 ADMI TTI NG					4.04
4.05	00405 PATIENT ACCOUNTING					4.05
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPING					9.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	128, 206				16.00
101.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	120, 200			I	
30.00	03000 ADULTS & PEDIATRICS	7, 706	738, 757	7	0 738, 757	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 140	138, 070		0 138, 070	31.00
41.00	04100 SUBPROVIDER - IRF	1, 094	162, 518		0 162, 518	41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	419	10, 117	4	0 10, 117	43.00
50.00	05000 OPERATI NG ROOM	20, 982	960, 625	5	0 960, 625	50.00
53.00	05300 ANESTHESI OLOGY	1, 875	22, 831		0 22, 831	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	26, 159	668, 551		0 668, 551	54.00
60.00	06000 LABORATORY	18, 881	281, 428		0 281, 428	60.00
65.00		3, 668	122, 379		0 122, 379 0 90, 587	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 327 1, 270	90, 587 21, 890		0 90, 587 0 21, 890	66. 00 67. 00
68.00	06800 SPEECH PATHOLOGY	448	5, 773		0 5, 773	68.00
69.00	06900 ELECTROCARDI OLOGY	3, 536	56, 424		0 56, 424	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	112	3, 754		0 3, 754	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	4,010	97, 965		0 97, 965	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	3, 237 8, 050	15, 445 80, 956		0 15, 445 0 80, 956	72.00 73.00
	03020 ONCOLOGY	470	72,063		0 72,063	75.00
	07697 CARDI AC REHABI LI TATI ON	341	23, 454		0 23, 454	
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	8, 270	206, 378		0 206, 378	
91.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	12, 982	206, 728	3	0 206, 728 0	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS				0	92.00
101.00	10100 HOME HEALTH AGENCY	1, 229	19, 742	2	0 19, 742	101.00
	SPECIAL PURPOSE COST CENTERS	1 1		i -		
	11300 INTEREST EXPENSE	100.00/		_		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	128, 206	4, 006, 435		0 4, 006, 435	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	47, 420		0 47, 420	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	499, 124		0 499, 124	192.00
192. Oʻ	19201 SOUTH CLINIC	0	C		0 0	192. 01
	19202 WEST CLINIC	0	C		0 0	192.02
	19203 DI ABETES CENTER	0	4, 362	2	0 4, 362	192.03
	19300 NONPAI D WORKERS 19301 ADULT/CHI LD CARE	0	41, 545		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	193. 00 193. 01
	19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING	0	41, 545	ő	0 41, 545	193.01
	19303 OPTI FAST/FOUNDATI ON	0	2, 895	5	0 2, 895	193. 03
194.00	07950 PARTNERSHI P HFC	0	17, 613		0 17, 613	194.00
194.01	07951 TRAFALGAR CLINIC	0	C	2	0 0	194. 01
	207952 EDI NBURGH	0	154		0 0	194.02
194.02		0	154		0 154	194.03
194. 02 194. 03			275	51	0 2751	110/ 0/
194.02 194.03 194.04	07954 ATHLETI C TRAI NERS	0	675		0 675 0 0	194.04 200.00
194. 02 194. 03	07954 ATHLETIC TRAINERS Cross Foot Adjustments	0	675 C C		0 675 0 0 0 0	194. 04 200. 00 201. 00

CUST A	Financial Systems LLOCATION - STATISTICAL BASIS	JOHNSON MEMOR	I AL HOSPITAL Provider C	CN: 15-0001 P	eriod: rom 01/01/2015	u of Form CMS-2 Worksheet B-1	2552-10
					o 12/31/2015	Date/Time Pre 1/16/2018 2:5	
		CAP	ITAL RELATED CO	OSTS			
	Cost Center Description	BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS	COMMUNI CATI ONS	
			(SQUARE FEET)		DEPARTMENT (GROSS	(# NON PT P HONES)	
		1.00	1.01	2.00	SALARIES) 4.00	4. 01	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	279, 616					1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT - TOWER	279,010					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2, 692, 463			2.00
4.00 4.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS	2, 984		1,902		1, 309	4.00 4.01
4.01	00402 DATA PROCESSING	6, 260		-	,	1, 309	
4.03	00403 MATERIALS MANAGEMENT	3, 826	0	5, 827		28	
4.04	00404 ADMI TTI NG	2, 239			570, 159	24	4.04
4.05 5.00	00405 PATIENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL	6, 650 9, 526		10, 096 25, 998		83	4.05 5.00
7.00	00700 OPERATION OF PLANT	24, 960			608, 085	39	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 404	0	4, 280		5	8.00
9.00	00900 HOUSEKEEPING	1,867				14	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	3, 917 4, 171			292, 768 455, 969	25	1
13.00	01300 NURSI NG ADMI NI STRATI ON	9, 867		31, 840		42	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 699	0	29, 931	73, 222	0	14.00
15.00	01500 PHARMACY	2,046		4, 778		17	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	3, 879	0	4, 649	477, 397	41	16.00
30.00	03000 ADULTS & PEDIATRICS	27, 577	17, 413	135, 534	2, 794, 421	99	30.00
31.00	03100 I NTENSI VE CARE UNI T	7, 886				28	
41.00	04100 SUBPROVIDER - IRF	6, 763				18	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	625	0	0	176, 154	0	43.00
50.00	05000 OPERATING ROOM	45, 761	714	354, 402	1, 735, 743	81	50.00
53.00	05300 ANESTHESI OLOGY	394				0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	16, 532				52	54.00
60. 00 65. 00	06500 RESPIRATORY THERAPY	8,049				68	60.00 65.00
66.00	06600 PHYSI CAL THERAPY	6, 338				21	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 335				4	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	83				4	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	182				2	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	10, 478		0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	0 6, 999			-	0 37	
	07697 CARDI AC REHABI LI TATI ON	2, 511	0	2,000		0	
	OUTPATIENT SERVICE COST CENTERS	1	1	1			
90.00 91.00	09000 CLINIC 09100 EMERGENCY	11, 516 9, 934				18 56	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	9,934	9, 665	34, 850	1, 721, 381	50	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	1, 305	0	730	681, 436	21	101.00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118.00		244, 932	75, 292	2, 617, 166	24, 147, 043	1, 115	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 297					190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 SOUTH CLINIC	25, 925	0	72, 865	8, 576, 910 0		192.00 192.01
	19202 WEST CLINIC	0	0	0	0		192.01
192.03	19203 DI ABETES CENTER	402	402	286	80, 467	3	192.03
	19300 NONPALD WORKERS	0	0	0	0		193.00
	19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING	4, 832			417, 480		193. 01 193. 02
	19303 OPTI FAST/FOUNDATI ON	0	0	0	0		193.02
194.00	07950 PARTNERSHI P HFC	2, 228	0	0	23, 520	8	194.00
	07951 TRAFALGAR CLINIC	0	0	0	0		194.01
	07952 EDI NBURGH 07953 JAI L				0 0		194. 02 194. 03
	07954 ATHLETIC TRAINERS		0	0	89, 628		194.03
200.00							200.00
		1	1	1	1		201.00
200.00 201.00 202.00		1, 829, 904	86, 509	2, 703, 810	7, 337, 071	502, 753	1

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2015	Worksheet B-1	
				To 12/31/2015		pared: 2 pm
	CAPI TAL RELATED COSTS					
Cost Center Description	BLDG & FIXT (TOTAL FEET)	BLDG & FIXT - TOWER (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE		COMMUNI CATI ONS (# NON PT P HONES)	
	1.00	1.01	2.00	4. 00	4. 01	
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B, Part II)	6. 544347	1. 123625	1. 00421	4 0. 219707 21, 438		203. 00 204. 00
205.00 Unit cost multiplier (Wkst. B, Part				0.000642	2.061879	205. 00

	nancial Systems	JOHNSON MEMORI		N. 15 0001 D		u of Form CMS-2	2552-10
CUST ALLU	CATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Prep	oared:
	Cost Center Description	DATA	MATERI ALS	ADMI TTI NG		1/16/2018 2:53 Reconciliation	2 pm
		PROCESSING (WORK ORDER S)	MANAGEMENT (SUPPLY USA	(GROSS CHAR GES)	ACCOUNTING (GROSS CHAR		
		4.02	GE) 4.03	4.04	GES) 4. 05	5A	
	IERAL SERVICE COST CENTERS	I					
1.01 001	100 CAP REL COSTS-BLDG & FIXT 101 CAP REL COSTS-BLDG & FIXT - TOWER						1.00 1.01
	200 CAP REL COSTS-MVBLE EQUIP 100 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
	101 COMMUNI CATI ONS 102 DATA PROCESSI NG	1, 722					4.01 4.02
	ATERIALS MANAGEMENT	28	6, 953, 367				4.02
	104 ADMITTING 105 PATIENT ACCOUNTING	0 265	29, 546 42, 542	172, 841, 803 0	172, 841, 803		4.04 4.05
	500 ADMINISTRATIVE & GENERAL	141	42, 542 91, 865	0	172, 841, 803	-4, 423, 527	4.03 5.00
	OOOOOLAUNDDY & LINEN SEDVICE	22	1,800	0	0	0	7.00
	300 LAUNDRY & LINEN SERVICE 200 HOUSEKEEPING	4 0	606 1, 372	0	0	0	8.00 9.00
	DOO DI ETARY	73	208, 382	0	0	0	10.00
	100 CAFETERIA 300 NURSING ADMINISTRATION	0	0 71, 049	0	0	0	11.00 13.00
14.00 014	100 CENTRAL SERVICES & SUPPLY	0	55, 710	0	0	0	14.00
	500 PHARMACY 500 MEDICAL RECORDS & LIBRARY	24 108	0 2, 733	0	0	0	15. 00 16. 00
	PATIENT ROUTINE SERVICE COST CENTERS	100	2,733	0		0	10.00
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	248	180, 910		10, 385, 820	0	
	IOO SUBPROVIDER – IRF	0 62	54, 003 16, 222	1, 535, 860 1, 473, 861	1, 535, 860 1, 473, 861	0	31.00 41.00
43.00 043	300 NURSERY	0	0	564, 493	564, 493	0	43.00
	CILLARY SERVICE COST CENTERS	159	359, 702	28, 277, 229	28, 277, 229	0	50.00
	800 ANESTHESI OLOGY	0	1, 490		2, 526, 994	0	53.00
	100 RADI OLOGY-DI AGNOSTI C 2000 LABORATORY	162 0	274, 774	35, 312, 731	35, 312, 731	0	54.00 60.00
	500 RESPI RATORY THERAPY	67	994, 696 102, 591	25, 445, 745 4, 943, 262	25, 445, 745 4, 943, 262	0	65.00
	000 PHYSI CAL THERAPY	24	22, 144	3, 136, 431	3, 136, 431	0	66.00
	700 OCCUPATI ONAL THERAPY 300 SPEECH PATHOLOGY	5	26 105	1, 711, 813 604, 156	1, 711, 813 604, 156	0	67.00 68.00
69.00 069	200 ELECTROCARDI OLOGY	0	39, 541	4, 765, 320	4, 765, 320	0	69.00
	000 ELECTROENCEPHALOGRAPHY 100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 197 3, 038, 781	150, 473 5, 404, 580	150, 473 5, 404, 580	0	70.00 71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0	0,030,701	4, 363, 015	4, 363, 015	0	72.00
	300 DRUGS CHARGED TO PATIENTS 220 ONCOLOGY	0 15	11 590	10, 849, 257	10, 849, 257	0	73.00 76.00
	597 CARDI AC REHABI LI TATI ON	0	11, 580 9, 055		633, 293 459, 916	0	
	PATIENT SERVICE COST CENTERS		500 110	44.445.057	44.445.057		
	000 CLINIC 100 EMERGENCY	74 0	523, 413 93, 599		11, 145, 357 17, 495, 885	0	90.00 91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART			,,	,,		92.00
	HER REIMBURSABLE COST CENTERS	0	14, 318	1, 656, 312	1, 656, 312	0	101. 00
	CIAL PURPOSE COST CENTERS		14, 310	1,030,312	1,030,312	0	101.00
113.00113 118.00	300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	1 494	4 040 TEO	172 041 002	172 041 002	-4, 423, 527	113.00
	IREI MBURSABLE COST CENTERS	1, 484	6, 243, 752	172, 841, 803	172, 841, 803	-4, 423, 527	116.00
190.00190	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	40	13, 052	0	0		190.00
	200 PHYSICIANS' PRIVATE OFFICES 201 SOUTH CLINIC	198 0	620, 681 0	0	0		192. 00 192. 01
192.02 192	202 WEST CLINIC	0	0	0	Ő	0	192. 02
	203 DI ABETES CENTER 300 NONPAI D WORKERS	0	292 0	0	0		192. 03 193. 00
193.01 193	301 ADULT/CHI LD CARE	0	72, 815	0	0	0	193. 01
	302 PHYSICIAN OFFICE BUILDING 303 OPTIFAST/FOUNDATION	0	0	0	0		193. 02 193. 03
1	250 PARTNERSHIP HFC	0	2, 633	0	0		193.03 194.00
194.01079	251 TRAFALGAR CLINIC	0	0	0	0	0	194.01
194.02079 194.03079	252 EDI NBURGH 253 JAI L	0	0	0	0		194. 02 194. 03
194.04079	254 ATHLETI C TRAI NERS	0	142	0	Ő	0	194.04
200.00 201.00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	3, 065, 072	418, 903	753, 015	2, 221, 663		201.00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	1, 779. 948897	0. 060245	0. 004357	0. 012854		203. 00
203.00	Cost to be allocated (per Wkst. B,	1, 414, 706	54, 100		272, 417		203.00
	Part II)						

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2015	Worksheet B-1	
				To 12/31/2015		
Cost Center Description	DATA	MATERI ALS	ADMI TTI NG	PATI ENT	Reconciliation	
	PROCESSI NG	MANAGEMENT	(GROSS CHAR	ACCOUNT I NG		
	(WORK ORDER S)	(SUPPLY USA	GES)	(GROSS CHAR		
		GE)		GES)		
	4.02	4.03	4.04	4.05	5A	
205.00 Unit cost multiplier (Wkst. B, Part	821. 548200	0. 007780	0. 00009	9 0. 001576		205. 00

	Financial Systems LOCATION - STATISTICAL BASIS	JOHNSON MEMORI	Provider C		eri od:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2015 o 12/31/2015		
						1/16/2018 2:5	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPING (TOTAL FEET)	DI ETARY (MEALS SERVED)	
		(ACCUM. COST)	(TOTAL FEET)	(POUNDS OF		(WEALS SERVED)	
		5.00	7.00	LAUNDR)		40.00	
C	GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	-
	DO100 CAP REL COSTS-BLDG & FIXT						1 1
	DO101 CAP REL COSTS-BLDG & FIXT - TOWER		- -				1
	00200 CAP REL COSTS-MVBLE EQUIP						2
	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS						
	DO402 DATA PROCESSING						
03 0	DO403 MATERIALS MANAGEMENT						4
	DO404 ADMITTING						4
	00405 PATIENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL	64, 288, 453					4
	DO700 OPERATION OF PLANT	2, 938, 109					
	DO800 LAUNDRY & LINEN SERVICE	246, 280	2, 404				8
	DO900 HOUSEKEEPI NG	915, 468	1, 867			(
	01000 DI ETARY 01100 CAFETERI A	668, 666 501, 626	3, 917 4, 171			6, 895 0	
	01300 NURSI NG ADMI NI STRATI ON	1, 865, 071	9, 867			0	
	01400 CENTRAL SERVICES & SUPPLY	242, 641	1, 699	C	1, 699	0	14
	D1500 PHARMACY	4, 039, 281	2,046			0	1
	01600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	1, 036, 875	3, 879	C	3, 879	0	1
	D3000 ADULTS & PEDIATRICS	4, 352, 082	27, 577	120, 785	27, 577	4, 769	30
	D3100 I NTENSI VE CARE UNI T	1, 555, 281	7, 886			935	
	04100 SUBPROVIDER – IRF	1, 063, 033	6, 763			1, 191	
	04300 NURSERY	254, 682	625	C	625	0	4
	ANCILLARY SERVICE COST CENTERS	4, 290, 500	45, 761	104, 999	45, 761	0	5
	D5300 ANESTHESI OLOGY	80, 138	394			0	
	05400 RADI OLOGY-DI AGNOSTI C	4, 665, 149	16, 532			0	
	06000 LABORATORY	4, 165, 661	8,049			0	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 441, 494 1, 043, 996	3, 374 6, 338		-,	0	6
	06700 OCCUPATI ONAL THERAPY	306, 912				0	6
	D6800 SPEECH PATHOLOGY	172, 818	83	C		0	6
		872, 566	1, 080			0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	71,076	182 0		-	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 526, 381	0		-	0	
	D7300 DRUGS CHARGED TO PATIENTS	186, 726	0		-	0	
	03020 ONCOLOGY	313, 761	6, 999			0	
	D7697 CARDIAC REHABILITATION DUTPATIENT SERVICE COST CENTERS	181, 524	2, 511	C	2, 511	0	7
	DODO CLINIC	3, 097, 178	11, 516	3, 530	11, 516	0	9
00 0	D9100 EMERGENCY	2, 800, 441	9, 934			0	9'
	09200 OBSERVATION BEDS (NON-DISTINCT PART						9
	DTHER REIMBURSABLE COST CENTERS	1, 057, 469	1, 305	C	1, 305	0	10
	SPECIAL PURPOSE COST CENTERS	1,037,407	1, 303		1, 303	0	10
. 00 1	11300 INTEREST EXPENSE						11:
3. 00	SUBTOTALS (SUM OF LINES 1-117)	47, 862, 257	188, 094	489, 674	183, 823	6, 895	11
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	191, 402	1, 297		1, 297	0	19
	19200 PHYSI CLANS' PRI VATE OFFI CES	14, 389, 849	25, 925				19:
. 01 1	19201 SOUTH CLINIC	0	C		0		19
	19202 WEST CLINIC	0	0		-		19
	19203 DI ABETES CENTER 19300 NONPAI D WORKERS	109, 407	402	C C	402		19: 19:
	19301 ADULT/CHI LD CARE	611, 234	4, 832		4, 832		19
. 02 1	19302 PHYSICIAN OFFICE BUILDING	0	0		0	0	19
1	19303 OPTI FAST/FOUNDATI ON	901, 902	0	C	0		19:
	07950 PARTNERSHI P HFC 07951 TRAFALGAR CLI NI C	52,095	2, 228	C C	2, 228		194 194
	07951 TRAFALGAR CLINIC 07952 EDI NBURGH	0			0 0		194
. 03 0	07953 JAI L	48,000	c c	d d	0		194
. 04 0	07954 ATHLETI C TRAI NERS	122, 307	0	C	0	0	194
0.00	Cross Foot Adjustments						200
1.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	4, 423, 527	3, 140, 271	297, 113	1, 060, 210		20
	Part I)	4, 423, 327	5, 140, 271	271, 113	1,000,210	172,000	
3. 00	Unit cost multiplier (Wkst. B, Part I)		14. 095965				
4.00	Cost to be allocated (per Wkst. B, Part II)	206, 351	233, 937	26, 724	25, 905	109, 669	204

Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2015	Worksheet B-1	
				o 12/31/2015	Date/Time Pre 1/16/2018 2:5	
Cost Center Description	ADMI NI STRATI VE	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE	(TOTAL FEET)	(MEALS SERVED)	
	(ACCUM. COST)	(TOTAL FEET)	(POUNDS OF			
			LAUNDR)			
	5.00	7.00	8.00	9.00	10.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 003210	1. 050090	0. 053404	0. 118555	15. 905584	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	JOHNSON MEMOR	Provider CC		Period:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2015 o 12/31/2015	Date/Time Pre 1/16/2018 2:5	
	Cost Center Description	CAFETERI A (HOURS PAID)	NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG HR)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LI BRARY (GROSS CHAR GES)	2 pm
		11.00	13.00	14.00	15.00	16.00	
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 4.\ 01\\ 4.\ 02\\ 4.\ 03\\ 4.\ 04\\ 4.\ 05\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - TOWER 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT 00404 ADMITTING 00404 ADMITTING 00405 PATIENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	784, 774 23, 229 4, 263 12, 587	269, 965	10C C			1.00 1.01 2.00 4.01 4.02 4.03 4.04 4.05 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00
	01600 MEDICAL RECORDS & LIBRARY	26, 507		C		172, 841, 803	
30. 00 31. 00 41. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04300 NURSERY	88, 119 36, 711 21, 508 6, 317	36, 711 21, 508	C C C C	0 0 0 0	10, 385, 820 1, 535, 860 1, 473, 861 564, 493	31.00 41.00
50.00	ANCI LLARY SERVI CE COST CENTERS	60, 080	60, 080	C	0	28, 277, 229	50.00
53.00 54.00 60.00 65.00 66.00 67.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 65, 283 63, 470 29, 186 22, 904 6, 144				2, 526, 994 35, 312, 731 25, 445, 745 4, 943, 262 3, 136, 431 1, 711, 813	54.00 60.00 65.00 66.00 67.00
72. 00 73. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03020 ONCOLOGY	3, 430 11, 322 1, 815 C C C C 5, 919		C C C 10C C C C C C C C C C	0 0 0 0 0 0 0 0 100	604, 156 4, 765, 320 150, 473 5, 404, 580 4, 363, 015 10, 849, 257 633, 293	69.00 70.00 71.00 72.00 73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	3, 775	0	C	0	459, 916	76.97
	OUTPATI ENT SERVICE COST CENTERS 09000 CLINIC 09100 EMERGENCY	27,054 57,230		C C		11, 145, 357 17, 495, 885	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00	INTER REINDROADLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	22, 019	0	C	0 0	1, 656, 312	101. 00
113. 00 118. 00	11300 INTEREST EXPENSE	598, 872	269, 965	100	100	172, 841, 803	113. 00 118. 00
192.00 192.01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 SOUTH CLINIC 19202 WEST CLINIC	3, 627 136, 408 C	1 1	C C C		0 0	190.00 192.00 192.01 192.02
192. 03 193. 00 193. 01	19203 DI ABETES CENTER 19300 NONPAI D WORKERS 19301 ADULT/CHI LD CARE	2, 548 C 33, 347	0			0 0 0	192. 03 193. 00 193. 01
193.03 194.00 194.01 194.02	19302 PHYSI CI AN OFFI CE BUILDING 19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI PHFC 07951 TRAFALGAR CLINI C 07952 EDI NBURGH	C C 4, 828 C C C		C C C C C		0 0 0 0	193. 02 193. 03 194. 00 194. 01 194. 02
194.04 200.00	5	C 5, 144	0 . 0	C	0 0		194. 03 194. 04 200. 00
201.00 202.00	0	615, 173	2, 198, 570	294, 871	4, 365, 846	1, 202, 496	201.00 202.00
203.00		0. 783886	8. 143908	2, 948. 710000	43, 658. 460000	0.006957	203.00

Health Fina	ancial Systems	JOHNSON MEMOR	I AL_HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOC	ATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1		
					rom 01/01/2015 To 12/31/2015	Date/Time Pre 1/16/2018 2:5		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		(HOURS PAID)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
				SUPPLY	REQUIS.)	LI BRARY		
			(DI RECT NRS	(COSTED		(GROSS CHAR		
			ING HR)	REQUIS.)		GES)		
		11.00	13.00	14.00	15.00	16.00		
204.00	Cost to be allocated (per Wkst. B, Part II)	34, 073	116, 532	44, 605	5 54, 135	128, 206	204.00	
205.00	Unit cost multiplier (Wkst. B, Part)	0. 043418	0. 431656	446.05000	541. 350000	0.000742	205. 00	

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 1/16/2018 2:5	pared: 2 pm
		Title	e XVIII	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1100	2100	0.00		0100	
30. 00 03000 ADULTS & PEDI ATRI CS	6, 653, 132		6, 653, 13	2 0	6, 653, 132	30.00
31. 00 03100 I NTENSI VE CARE UNI T	2, 278, 561		2, 278, 56		2, 278, 561	
41. 00 04100 SUBPROVIDER – I RF	1, 614, 347		1, 614, 34		1, 614, 347	1
43. 00 04300 NURSERY	344, 373		344, 37		344, 373	
ANCI LLARY SERVI CE COST CENTERS	,			-		
50. 00 05000 OPERATI NG ROOM	6, 248, 246		6, 248, 24	6 0	6, 248, 246	50.00
53.00 05300 ANESTHESI OLOGY	110, 698		110, 69		110, 698	
54.00 05400 RADI OLOGY-DI AGNOSTI C	5, 614, 304		5, 614, 30		5, 614, 304	1
60. 00 06000 LABORATORY	4, 831, 579		4, 831, 57		4, 831, 579	1
65. 00 06500 RESPI RATORY THERAPY	1, 661, 878				1, 661, 878	
66. 00 06600 PHYSI CAL THERAPY	1, 277, 047		1, 277, 04		1, 277, 047	
67.00 06700 OCCUPATI ONAL THERAPY	370, 051		370, 05		370, 051	
68.00 06800 SPEECH PATHOLOGY	193, 174	0	193, 17	4 0	193, 174	
69. 00 06900 ELECTROCARDI OLOGY	996, 574		996, 57	4 0	996, 574	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	81, 885		81, 88	5 0	81, 885	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 373, 221		2, 373, 22	1 0	2, 373, 221	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 661, 760		1, 661, 76	0 0	1, 661, 760	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 640, 898		4, 640, 89	8 0	4, 640, 898	73.00
76.00 03020 ONCOLOGY	477, 014		477, 01	4 0	477, 014	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	247, 752		247, 75	2 0	247, 752	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	3, 629, 332		3, 629, 33	2 0	3, 629, 332	90.00
91.00 09100 EMERGENCY	3, 856, 652		3, 856, 65	2 0	3, 856, 652	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 061, 884		1, 061, 88	4	1, 061, 884	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	1, 183, 740		1, 183, 74	0	1, 183, 740	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	51, 408, 102	0	51, 408, 10	2 0	51, 408, 102	200. 00
201.00 Less Observation Beds	1, 061, 884		1, 061, 88		1, 061, 884	
202.00 Total (see instructions)	50, 346, 218	0	50, 346, 21	8 0	50, 346, 218	202.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0001	Period: From 01/01/2015	Worksheet C Part I	
				To 12/31/2015	Date/Time Pre 1/16/2018 2:5	epared: 2 pm
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-11					
30. 00 03000 ADULTS & PEDIATRICS	8, 818, 465		8, 818, 46			30.00
31.00 03100 INTENSIVE CARE UNIT	1, 535, 860		1, 535, 86			31.00
41.00 04100 SUBPROVIDER - IRF	1, 473, 861		1, 473, 86			41.00
43. 00 04300 NURSERY	564, 493		564, 49	93		43.00
ANCI LLARY SERVI CE COST CENTERS	-					
50.00 05000 OPERATING ROOM	5, 258, 093	23, 019, 136			0.00000	
53. 00 05300 ANESTHESI OLOGY	614, 480	1, 912, 514			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 435, 687	31, 877, 044	35, 312, 73		0.00000	
60. 00 06000 LABORATORY	4, 971, 948	20, 473, 797			0.00000	
65. 00 06500 RESPI RATORY THERAPY	2, 375, 722	2, 567, 540			0.00000	
66. 00 06600 PHYSI CAL THERAPY	936, 085	2, 200, 346	3, 136, 43		0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	953, 595	758, 218	1, 711, 81	0. 216175	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	307, 019	297, 137	604, 15	0. 319742	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	921, 477	3, 843, 843	4, 765, 32	0. 209131	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	51, 932	98, 541	150, 47	0. 544184	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 870, 569	2, 534, 011	5, 404, 58	0. 439113	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6,000	4, 357, 015	4, 363, 01	0. 380874	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 778, 463	7,070,794	10, 849, 25	0. 427762	0.00000	
76.00 03020 ONCOLOGY	490	632, 803	633, 29	0. 753228	0.00000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 080	458, 836	459, 91	0. 538690	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLINIC	20, 653	11, 124, 704	11, 145, 35	0. 325636	0.00000	90.00
91. 00 09100 EMERGENCY	2, 354, 962	15, 140, 923		0. 220432	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	505, 732	1, 061, 623	1, 567, 35	0. 677501	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1, 656, 312	1, 656, 31	12		101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	41, 756, 666	131, 085, 137	172, 841, 80)3		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	41, 756, 666	131, 085, 137	172, 841, 80)3		202.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 1/16/2018 2:52 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
41. 00 04100 SUBPROVIDER - IRF				41.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 220964			50.00
53.00 05300 ANESTHESI OLOGY	0.043806			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 158988			54.00
60. 00 06000 LABORATORY	0. 189878			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 336191			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 407166			66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 216175			67.00
68.00 06800 SPEECH PATHOLOGY	0. 319742			68.00
69.00 06900 ELECTROCARDI OLOGY	0. 209131			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 544184			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 439113			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 380874			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 427762			73.00
76.00 03020 ONCOLOGY	0. 753228			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 538690			76.97
OUTPATIENT SERVICE COST CENTERS	• •			
90. 00 09000 CLI NI C	0. 325636			90.00
91. 00 09100 EMERGENCY	0. 220432			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 677501			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
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

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2015	Worksheet C Part I	
				To 12/31/2015	Date/Time Pre 1/16/2018 2:5	pared: 2 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 653, 132		6, 653, 13	2 0	6, 653, 132	
31.00 03100 INTENSIVE CARE UNIT	2, 278, 561		2, 278, 56	1 0	2, 278, 561	31.00
41. 00 04100 SUBPROVIDER – IRF	1, 614, 347		1, 614, 34		1, 614, 347	
43. 00 04300 NURSERY	344, 373		344, 37	3 0	344, 373	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	6, 248, 246		6, 248, 24		6, 248, 246	
53. 00 05300 ANESTHESI OLOGY	110, 698		110, 69	в 0	110, 698	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	5, 614, 304		5, 614, 30	4 0	5, 614, 304	54.00
60. 00 06000 LABORATORY	4, 831, 579		4, 831, 57	9 0	4, 831, 579	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 661, 878	C	1, 661, 87	в О	1, 661, 878	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 277, 047	C	1, 277, 04	7 0	1, 277, 047	66.00
67.00 06700 OCCUPATI ONAL THERAPY	370, 051	C	370, 05	1 0	370, 051	67.00
68.00 06800 SPEECH PATHOLOGY	193, 174	C) 193, 17	4 0	193, 174	68.00
69. 00 06900 ELECTROCARDI OLOGY	996, 574		996, 57	4 0	996, 574	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	81, 885		81, 88	5 0	81, 885	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 373, 221		2, 373, 22	1 0	2, 373, 221	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 661, 760		1, 661, 76	o c	1, 661, 760	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 640, 898		4, 640, 89	в о	4, 640, 898	73.00
76.00 03020 ONCOLOGY	477, 014		477, 01	4 0	477, 014	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	247, 752		247, 75	2 0	247, 752	76.97
OUTPATIENT SERVICE COST CENTERS				_		
90. 00 09000 CLINIC	3, 629, 332		3, 629, 33	2 0	3, 629, 332	90.00
91.00 09100 EMERGENCY	3, 856, 652		3, 856, 65	2 0	3, 856, 652	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 061, 884		1, 061, 88	4	1, 061, 884	92.00
OTHER REIMBURSABLE COST CENTERS				- .		
101.0010100 HOME HEALTH AGENCY	1, 183, 740		1, 183, 74	C	1, 183, 740	101.00
SPECIAL PURPOSE COST CENTERS				-		
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	51, 408, 102	C			51, 408, 102	
201.00 Less Observation Beds	1, 061, 884		1, 061, 88		1, 061, 884	
202.00 Total (see instructions)	50, 346, 218	C	50, 346, 21	8 0	50, 346, 218	202.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0001	Period: From 01/01/2015	Worksheet C Part I	
				To 12/31/2015		pared:
					1/16/2018 2:5	2 pm
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	8, 818, 465		8, 818, 40	5		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 535, 860		1, 535, 80			31.00
41. 00 04100 SUBPROVIDER - IRF	1, 473, 861		1, 473, 80			41.00
43. 00 04300 NURSERY	564, 493		564, 49			43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	5, 258, 093	23, 019, 136	28, 277, 22	0. 220964	0. 000000	50.00
53. 00 05300 ANESTHESI OLOGY	614, 480	1, 912, 514				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 435, 687	31, 877, 044			0.000000	54.00
60. 00 06000 LABORATORY	4, 971, 948	20, 473, 797	25, 445, 74	5 0. 189878	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	2, 375, 722	2, 567, 540	4, 943, 20	0. 336191	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	936, 085	2, 200, 346	3, 136, 43	0. 407166	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	953, 595	758, 218	1, 711, 8	3 0. 216175	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	307, 019	297, 137	604, 15	6 0. 319742	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	921, 477	3, 843, 843	4, 765, 32	0. 209131	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	51, 932	98, 541	150, 41	3 0. 544184	0.00000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 870, 569	2, 534, 011	5, 404, 58	0. 439113	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6,000	4, 357, 015	4, 363, 01		0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 778, 463	7, 070, 794				
76. 00 03020 ONCOLOGY	490	632, 803				
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 080	458, 836	459, 91	6 0. 538690	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	20, 653	11, 124, 704				
91. 00 09100 EMERGENCY	2, 354, 962	15, 140, 923				
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	505, 732	1, 061, 623	1, 567, 3	0. 677501	0. 000000	92.00
OTHER REI MBURSABLE COST CENTERS			1 (5(0)			1.0.1.00
101.00 10100 HOME HEALTH AGENCY	0	1, 656, 312	1, 656, 3	2		101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE			1			112 00
	41 754 444	101 005 107	172 041 0			113.00 200.00
200.00Subtotal (see instructions)201.00Less Observation Beds	41, 756, 666	131, 085, 137	172, 841, 80	13		200.00
201.00Less Observation Beds202.00Total (see instructions)	41, 756, 666	131, 085, 137	172, 841, 80	2		201.00
	41,700,000	131,000,137	1/2,041,80	13		1202.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prep 1/16/2018 2:52	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
41.00 04100 SUBPROVIDER - IRF					41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·				
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
60. 00 06000 LABORATORY	0.000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0, 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0.000000				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0,000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00 03020 ONCOLOGY	0.000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS	• •				
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	· · ·				
101.00 10100 HOME HEALTH AGENCY				1	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds				2	201.00
202.00 Total (see instructions)				2	202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider CO		Period: From 01/01/2015 To 12/31/2015		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)	2.00	2)	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 41.00 SUBPROVIDER - IRF 43.00 NURSERY 200.00 Total (lines 30-199) Cost Center Description	738, 757 138, 070 162, 518 10, 117 1, 049, 462 Inpati ent Program days	0	738, 75 138, 07 162, 51 10, 11 1, 049, 46	0 935 8 1, 191 7 650	147. 67 136. 46 15. 56	31.00
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 41. 00 SUBPROVIDER - IRF 43. 00 NURSERY	2, 448 256 503 0	37, 804				30.00 31.00 41.00 43.00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CA	API TAL COSTS	Provider C		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Pre 1/16/2018 2:5	pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	: Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)	_		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 ODERATING ROOM	960, 625	28, 277, 229	0. 03397	2 2, 064, 798	70, 145	50.00
53. 00 05300 ANESTHESI OLOGY	22, 831	2, 526, 994	0.00903	5 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	668, 551	35, 312, 731	0. 01893	2 1, 743, 680	33, 011	54.00
60. 00 06000 LABORATORY	281, 428	25, 445, 745	0. 01106	0 2, 489, 943	27, 539	60.00
65. 00 06500 RESPI RATORY THERAPY	122, 379	4, 943, 262	0. 02475	7 1, 112, 753	27, 548	65.00
66. 00 06600 PHYSI CAL THERAPY	90, 587	3, 136, 431	0. 02888	2 233, 368	6, 740	66. OC
67.00 06700 OCCUPATIONAL THERAPY	21, 890	1, 711, 813	0. 01278	8 228, 211	2, 918	67.00
68.00 06800 SPEECH PATHOLOGY	5, 773	604, 156	0. 00955	5 61, 752	590	68.00
69. 00 06900 ELECTROCARDI OLOGY	56, 424	4, 765, 320	0. 01184	1 741, 863	8, 784	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	3, 754	150, 473	0. 02494	8 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	Г 97, 965	5, 404, 580	0. 01812	6 1, 691, 476	30, 660	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 445	4, 363, 015	0. 00354	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	80, 956	10, 849, 257	0. 00746	2 1, 906, 289	14, 225	73.00
76.00 03020 ONCOLOGY	72, 063	633, 293	0. 11379	1 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	23, 454	459, 916	0. 05099	6 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	·					1
90. 00 09000 CLINIC	206, 378	11, 145, 357	0. 01851	7 15, 934	295	90.00
91.00 09100 EMERGENCY	206, 728	17, 495, 885	0. 01181	6 1, 063, 956	12, 572	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	Г 117, 911	1, 567, 355	0. 07522	9 104, 842	7, 887	92.00
200.00 Total (lines 50-199)	3, 055, 142	158, 792, 812		13, 458, 865	242, 914	200 00

Health Financial Systems	JOHNSON MEMOR	I AL_HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		-	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 1/16/2018 2:5	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adj ustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	C)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	C) c		o	0	31.00
41.00 04100 SUBPROVIDER - IRF	0			0 0	0	41.00
43. 00 04300 NURSERY				0	0	
200.00 Total (lines 30-199)				0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	Inpati ent		
	Days	$5 \div col. 6)$	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6,00	7.00	8,00	9,00		
INPATIENT ROUTINE SERVICE COST CENTERS					1	
30. 00 03000 ADULTS & PEDI ATRI CS	5, 595	0.00	2,44	8 0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	935					31.00
41. 00 04100 SUBPROVI DER – I RF	1, 191					41.00
43. 00 04300 NURSERY	650			0 0		43.00
200.00 Total (lines 30-199)	8, 371		3, 20	7 0		200.00
200.00 [10101 (11103 30-177)]	0, 571	I	J 3,20	'I 0	1	200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	5 Provider C	CN: 15-0001	Period: From 01/01/2015	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2015		pared [.]
				10 12/01/2010	1/16/2018 2:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	th All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	-		1		-	
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
76. 00 03020 ONCOLOGY	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	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
200.00 Total (lines 50-199)	0	0	4	0 0	0	200. 00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	narad
				10 12/31/2015	1/16/2018 2:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50. 00 05000 OPERATI NG ROOM	0	28, 277, 229				
53. 00 05300 ANESTHESI OLOGY	0	2, 526, 994				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	35, 312, 731				
60. 00 06000 LABORATORY	0	25, 445, 745			2, 489, 943	
65. 00 06500 RESPI RATORY THERAPY	0	4, 943, 262				
66. 00 06600 PHYSI CAL THERAPY	0	3, 136, 431			233, 368	
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 711, 813				67.00
68.00 06800 SPEECH PATHOLOGY	0	604, 156				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	4, 765, 320				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	150, 473				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 404, 580	0.00000	0 0.000000	1, 691, 476	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 363, 015	0.00000	0 0.000000		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 849, 257	0.00000	0 0.000000	1, 906, 289	73.00
76. 00 03020 ONCOLOGY	0	633, 293	0.00000	0.000000	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	459, 916	0.00000	0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	11, 145, 357	0.00000	0.000000	15, 934	90.00
91. 00 09100 EMERGENCY	0	17, 495, 885				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 567, 355	0.00000	0.00000		
200.00 Total (lines 50-199)	0	158, 792, 812			13, 458, 865	200. 00

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PASS	Provider C	CN: 15-0001	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	narod
				10 12/31/2015	1/16/2018 2:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug	n		
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	4, 687, 066		0		50.00
53. 00 05300 ANESTHESI OLOGY	0	791, 746		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	7, 994, 580		0		54.00
60. 00 06000 LABORATORY	0	1, 287, 175		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	217, 212		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 636		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	196		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 116, 123		0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	885, 653		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	844, 044		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 048, 240		0		73.00
76.00 03020 ONCOLOGY	0	65, 013		0		76.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0		76.97
OUTPATIENT SERVICE COST CENTERS			-			
90. 00 09000 CLINIC	0	3, 194, 632		0		90.00
91.00 09100 EMERGENCY	0	2, 638, 916		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	296, 298		0		92.00
200.00 Total (lines 50-199)	0	28, 068, 530		0		200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2015 To 12/31/2015		
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						-
50.00 OPERATING ROOM	0. 220964	4, 687, 066		0 0	1, 035, 673	
53. 00 05300 ANESTHESI OLOGY	0. 043806	791, 746		0 0	34, 683	•
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 158988			0 0	1, 271, 042	•
60. 00 06000 LABORATORY	0. 189878	1, 287, 175		7 0	244, 406	•
65. 00 06500 RESPI RATORY THERAPY	0. 336191	217, 212		0 0	73, 025	
66. 00 06600 PHYSI CAL THERAPY	0. 407166	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 216175	1, 636		0 0	354	67.00
68.00 06800 SPEECH PATHOLOGY	0. 319742	196		0 0	63	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 209131	2, 116, 123		0 0	442, 547	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 544184	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 439113	885, 653		0 0	388, 902	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 380874	844, 044		0 0	321, 474	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 427762	3, 048, 240		0 5, 143	1, 303, 921	73.00
76. 00 03020 ONCOLOGY	0. 753228	65, 013		0 0	48, 970	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 538690	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				-1		
90. 00 09000 CLINIC	0. 325636			9 0	1, 040, 287	•
91. 00 09100 EMERGENCY	0. 220432	2, 638, 916		0 0	581, 702	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 677501	296, 298		0 0	200, 742	•
200.00 Subtotal (see instructions)		28, 068, 530	1, 32	6 5, 143	6, 987, 791	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 +/- line 201)		28, 068, 530	1, 32	6 5, 143	6, 987, 791	202.00

Health Financial Systems	JOHNSON MEMOR				u of Form CMS	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CC		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pr 1/16/2018 2:	
	_		XVIII	Hospi tal	PPS	_
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				-
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0				50.0
53. 00 05300 ANESTHESI OLOGY	0	0				53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
	165	0				60.0
65. 00 06500 RESPI RATORY THERAPY	0	0				65.0
66. 00 06600 PHYSI CAL THERAPY	0	0				66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.0
68.00 06800 SPEECH PATHOLOGY	0	0				68.0
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0				71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 200				73.0
76. 00 03020 ONCOLOGY	0	0				76.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.9
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	149					90.0
91.00 09100 EMERGENCY	0	0				91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.0
200.00 Subtotal (see instructions)	314	2, 200				200.0
201.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	314	2, 200				202.0

Health Financial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Peri od:	Worksheet D	
		Component	CCN: 15-T001	From 01/01/2015 To 12/31/2015	Part II Date/Time Pre	narod
		Component	CCN. 15-1001	10 12/31/2015	1/16/2018 2:5	2 pm
		Title	e XVIII	Subprovider -	PPS	
	1	-		I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	5	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00	0.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	960, 625		0.03397	72 9,909	337	50.00
53. 00 05300 ANESTHESI OLOGY					11	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	22, 831				405	53.00 54.00
60. 00 06000 LABORATORY	668, 551					60.00
65. 00 06500 RESPIRATORY THERAPY	281, 428				1, 081 619	65.00
66. 00 06600 PHYSI CAL THERAPY	122, 379 90, 587					
67. 00 06700 OCCUPATI ONAL THERAPY	21, 890				3, 192	67.00
68. 00 06800 SPEECH PATHOLOGY	5, 773				3, 192	
69. 00 06900 ELECTROCARDI OLOGY	56, 424				78	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 754				/8	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	97, 965				267	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 445				16	
73. 00 07300 DRUGS CHARGED TO PATIENTS	80, 956				445	
76. 00 03020 ONCOLOGY	72,063				0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	23, 454				0	76.97
OUTPATIENT SERVICE COST CENTERS	20/101	10,7,710	010007			
90. 00 09000 CLINIC	206, 378	11, 145, 357	0.0185	17 0	0	90.00
91. 00 09100 EMERGENCY	206, 728			-	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	
200.00 Total (lines 50-199)	2, 937, 231			841, 586	14, 177	200.00

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CC	CN: 15-0001	Peri od:	Worksheet D	
THROUGH COSTS		Component (CCN: 15-T001	From 01/01/2015 To 12/31/2015		pared [.]
					1/16/2018 2:5	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Non Physician Nu	ursing School	Allied Healt		Total Cost	
	Anesthetist Cost			Medical	(sum of col 1	
	COST			Education Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
76.00 03020 ONCOLOGY	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		0				00.00
90. 00 09000 CLINIC	0	0		0 0	0	101.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50-199)	0	0		0 0	0	92.00 200.00
200.00 10tal (11185 00-199)	I U	U	1	0	0	∠UU. UU

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	ERVICE OTHER PAS	S Provider C	CN: 15-0001	Period:	Worksheet D	
HROUGH COSTS						
		Component (From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	nared
		oomponente	. 10 1001	10 12/01/2010	1/16/2018 2:5	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Total	Total Charges			Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of				Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	0.00	7)	40.00	
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	0	20 277 220	0.00000		0.000	50.00
0.00 05000 OPERATING ROOM	0	20/2///22/			9, 909	50.00
3. 00 05300 ANESTHESI OLOGY	0	2, 526, 994			1, 196	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	35, 312, 731			21, 372	54.00
	0	25, 445, 745			97, 736	60.00
5.00 06500 RESPI RATORY THERAPY	0	4, 943, 262			25, 021	65.00
6.00 06600 PHYSI CAL THERAPY	0	3, 136, 431			235, 640	
7.00 06700 OCCUPATIONAL THERAPY	0	1, 711, 813			249, 626	
8.00 06800 SPEECH PATHOLOGY	0	604, 156			96, 336	
9. 00 06900 ELECTROCARDI OLOGY	0	4, 765, 320			6, 604	
0.00 07000 ELECTROENCEPHALOGRAPHY	0	150, 473			0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	5, 404, 580			14, 706	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 363, 015			4, 625	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 849, 257			59, 669	73.00
6. 00 03020 ONCOLOGY	0	633, 293	0.00000	0 0. 000000	0	76.00
6. 97 07697 CARDI AC REHABI LI TATI ON	0	459, 916	0.00000	0 0.000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	0	11, 145, 357			0	90.00
1. 00 09100 EMERGENCY	0	17, 495, 885	0.00000	0 0. 000000	0	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 567, 355	0.00000	0 0. 000000	19, 146	92.00
00.00 Total (lines 50-199)	0	158, 792, 812			841, 586	200.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-0001	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T001	From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	oparod:
		component	CCN. 15-1001	10 12/31/2015	1/16/2018 2:5	52 pm
		Title	e XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS						50.00
50. 00 05000 OPERATING ROOM	0	C		0		50.00
53. 00 05300 ANESTHESI OLOGY	0	C		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
60. 00 06000 LABORATORY	0	C		0		60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0		73.00
76.00 03020 ONCOLOGY	0	C)	0		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C)	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	60)	0		90.00
91.00 09100 EMERGENCY	0	C)	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.00
200.00 Total (lines 50-199)	0	60)	0		200. 00

APPORTIONMENT OF MEDICAL. OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0001 Period: To 12/31/2015 Worksheet D Part V Date/Time Prepared: 1/16/2018 2:52 m Cost Center Description Cost to Charges Cost Cos	Heal th Fina	ncial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ANCI LLARY SERVICE COST CENTERS Cost of charge Cost conter Description Cost of charge Cost conter Description Cost contesconter Description Cost conteresconte	APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST			From 01/01/2015	Part V	paradi
Cost Center Description Cost to Charge Ratio From Worksheet C, Part I, col. 9 Charges Cost inst.) Cost Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) PPS Services (see Services Subject To Ded. & Coins. (see inst.) 4MCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 0.220964 0 0 0 50.00 50.00 05000 ARSTHESIOLOGY 0.043806 0 0 0 50.00 50.00 06000 RESPIRATING ROOM 0.220964 0 0 0 50.00 50.00 05000 OPERATING ROOM 0.220964 0 0 0 50.00 50.00 06000 RESPIRATORY THERPY 0.189878 0 0 0 53.00 66.00 06000 PESPIRATORY THERPY 0.36191 0 0 0 66.00 67.00 065000 OPECPHATORY THERPY 0.216175 0 0 0 0 67.00 68.00 066000 PHYSICAL THERAPY 0.216175 0 0 0 0 0				component	JCN: 15-1001	10 12/31/2015		
Cost Center Description Cost to Charges Costs Costs <thcosts< th=""> Costs Costs</thcosts<>				Title	XVIII	Subprovider -		
ANCILLARY SERVICE COST CENTERS Cost 0 Cost 0 Cost 0 Cost 0 PS Services 0 Reimbursed 0 Services 0 Reimbursed 0 Subject 70 Ded. & Coins. (see inst.) Subject 70 Ded. & Coins. (see inst.) <td></td> <td></td> <td></td> <td></td> <td></td> <td>I RF</td> <td></td> <td></td>						I RF		
Artio From Worksheet C, Part I, col. 9 Services (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 50.00 05000 (PERATING ROM 0.220964 0 0 0 50.00 50.00 05000 (PERATING ROM 0.220964 0 0 0 50.00 50.00 05000 (DPERATING ROM 0.220964 0 0 0 50.00 50.00 05000 (DP-DIAGNOSTI C 0.189878 0 0 0 66.00 66.00 06500 (RSPI RATORY THERAPY 0.386191 0 0 0 66.00 66.00 06500 (SPECH PATHORARY 0.319742 0 0 0 66.00 67.00 06700 (OCUPATIONAL THERAPY 0.249131 0 0 0 0 67.00 70.00 06700 OCUPATIONAL THERAPY 0.240131 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
ANCI LLARY SERVICE COST CENTERS Norksheet C, Part I, col. 9 inst.) Services Subject To Ded. & Coins. (see inst.) Services Not Subject To Ded. & Coins. (see inst.) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROOM 0.220964 0 0 0 50.00 51.00 05400 RADI OLOGY 0.043806 0 0 0 53.00 56.00 05600 RSPI RORY 0.189878 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.336191 0 0 0 66.00 66.00 06600 SPEECH PATHOLOGY 0.319742 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.299131 0 0 0 71.00 71.00 07100 IELOTROCARDI OLOGY 0.38691 0 0 0 72.00 73.00 03020 INCLALTHERAPY 0.29131 0 0 0		Cost Center Description						
ANCILLARY SERVICE COST CENTERS Subject To Subject To Decl. & Coins. 50.00 05000 OPERATING ROOM 0.200 3.00 4.00 5.00 50.00 05000 OPERATING ROOM 0.220964 0 0 0 50.00 53.00 05300 ANESTHESI OLOGY 0.043806 0 0 0 53.00 64.00 06000 LABORATORY 0.189878 0 0 0 65.00 65.00 06500 PERJIANGRY THERAPY 0.336191 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.21715 0 0 0 67.00 67.00 06700 0CCUPATIONAL THERAPY 0.216175 0 0 0 68.00 6600 9600 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 0 0 69.00 69.00 70.00 71.00 0 0 71.00 71.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>(see inst.)</td> <td></td>							(see inst.)	
ANCI LLARY SERVICE COST CENTERS Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) 50.00 05000 0PERATING ROOM 0.220964 0 0 0 50.00 53.00 05300 ANDI CLEARY SERVICE COST CENTERS 0.220964 0 0 0 50.00 54.00 05400 ANDI OLOGY - DI AGNOSTI C 0.1389878 0 0 0 54.00 65.00 06500 RESPIRATORY THERAPY 0.336191 0 0 0 65.00 66.00 06600 HYSI CAL THERAPY 0.407166 0 0 0 66.00 67.00 064000 SEECH PATHOLOGY 0.216175 0 0 0 66.00 69.00 06800 SPEECH PATHOLOGY 0.299131 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.42762 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.32690 0 0 0 73.00								
ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROOM 0.220964 0 0 0 50.00 53.00 05300 ANESTHESI OLGY 0.043806 0 0 0 53.00 64.00 6400 ANESTHESI OLGY 0.158988 0 0 0 54.00 65.00 06500 RESPI RATORY 0.189878 0 0 0 66.00 66.00 06500 RESPI RATORY THERAPY 0.336191 0 0 0 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.216175 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.319742 0 0 0 68.00 70.00 07000 ELECTROCARDI OLOGY 0.209131 0 0 0 71.00 71.00 07100 MEDCAL SUPPLIES CHARGED TO PATI ENTS 0.380874 0 0 0 72.00			Part I, col. 9					
ANCI LLARY SERVI CE COST CENTERS 6.00 05000 OPERATI NG ROOM 0.220964 0 0 0 50.00 53.00 05300 AMESTHESI OLOGY 0.043806 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.158988 0 0 0 53.00 60.00 06000 LABORATORY 0.189978 0 0 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.336191 0 0 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.216175 0 0 0 67.00 0 67.00 0 67.00 0 68.00 69.00 0 68.00 69.00 0 68.00 69.00 0 0 68.00 69.00 70.00 0 69.00 70.00 0 69.00 70.00 0 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 72.00 73.00 73.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
ANCI LLARY SERVICE COST CENTERS 0 0 0 0 50.00 05000 OPERATI NG ROM 0.220964 0 0 0 50.00 50.00 50.00 0 53.00 0 53.00 0 53.00 0 53.00 0 0 0 53.00 0 0 0 53.00 0 0 0 53.00 0 0 0 53.00 0 0 0 53.00 0 0 0 53.00 0 0 0 53.00 0 0 0 53.00 0 0 0 54.00 0 0 0 54.00 <			1.00	2.00			F 00	
50.00 OSO00 OPERATING ROM 0.220964 0 0 0 50.00 53.00 05300 ANESTHESI OLOGY 0.043806 0 0 0 53.00 54.00 OSA00 RADI OLOGY-DI AGNOSTI C 0.158988 0 0 0 64.00 60.00 O6600 LABORATORY 0.189878 0 0 0 65.00 65.00 06500 RESPI RATORY THERAPY 0.336191 0 0 0 66.00 66.00 06700 0CUPATI ONAL THERAPY 0.216175 0 0 0 67.00 0 67.00 0 68.00 69.00 0 68.00 69.00 0 68.00 69.00 0 0 69.00 0 0 69.00 0	ANCLI	LADY SEDVICE COST CENTEDS	1.00	2.00	3.00	4.00	5.00	-
53.00 05300 ANESTHESI OLOGY 0.043806 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.158988 0 0 0 0 54.00 60.00 LABORATORY 0.189878 0 0 0 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.336191 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.407166 0 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0.216175 0 0 0 68.00 68.00 06800 SPECH PATHOLOGY 0.216175 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.216175 0 0 0 69.00 70.00 07000 ELECTROCARDI OLOGY 0.216175 0 0 0 0 70.00 70.00 07000 ELECTROCARDI OLOGY 0.209131 0 0 0 70.00 71.00 DOLAL SUPPLIES CHARGED TO PATI ENT 0.427762 0			0.220064	0	1	0 0	0	50.00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0.158988 0 0 0 64.00 60.00 06000 LABORATORY 0.189878 0 0 0 65.00 65.00 06500 RESPI RATORY THERAPY 0.336191 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.407166 0 0 0 66.00 67.00 06700 OCUPATIONAL THERAPY 0.216175 0 0 0 68.00 69.00 O6800 SPECH PATHOLOGY 0.319742 0 0 0 68.00 69.00 OF000 ELECTROCARDIOLOGY 0.209131 0 0 0 69.00 70.00 O7200 ILECTROENCEPHALOGRAPHY 0.544184 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.439113 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.380874 0 0 0 73.00 76.00 03202 NICOLOGY 0.753228							-	
60.00 LABORATORY 0.189878 0						0 0	-	
65.00 06500 RESPI RATORY THERAPY 0.336191 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.407166 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.216175 0 0 0 67.00 0 0 0 67.00 0 0 0 68.00 0 68.00 0 0 0 0 68.00 0 0 0 0 68.00 0 69.00 0 0 0 0 68.00 0 0 0 0 0 0 68.00 0 0 0 0 68.00 0						0 0	•	
66.00 06600 PHYSI CAL THERAPY 0.407166 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.216175 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.319742 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.209131 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.544184 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.439113 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.380874 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.427762 0 0 0 73.00 76.97 OR597 CARDI AC REHABI LI TATI ON 0.538690 0 0 0 76.97 0.7697 CARDI AC REHABI LI TATI ON 0.325636 60 0 0 91.00 91.00 91.00 0910						0 0	-	
67.00 06700 0CCUPATIONAL THERAPY 0.216175 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.319742 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.209131 0 0 0 69.00 70.00 07000 ELECTROCARDIOLOGY 0.209131 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.439113 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.380874 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.427762 0 0 0 73.00 76.00 03020 ONCOLOGY 0.753228 0 0 0 0 76.97 00170 DIPALIENT SERVICE COST CENTERS 0.325636 60 0 0 0 91.00 90.00 09100 EMERGENCY 0.325636 60 0 0 91.00 91.00 92.00 09200 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>0 0</td><td>•</td><td></td></td<>						0 0	•	
68.00 06800 SPEECH PATHOLOGY 0.319742 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.209131 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.544184 0 0 0 0 70.00 71.00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.439113 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.380874 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0 0 0 74.00 74.						0 0	-	
69.00 06900 ELECTROCARDIOLOGY 0.209131 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.544184 0 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.439113 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.380874 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.427762 0 0 205 0 73.00 76.00 03202 ONCOLOGY 0.753228 0 0 0 76.00 76.00 76.97 74.97 07697 CARDIAC REHABILITATION 0.538690 0 0 0 76.97 0.00 09000 CLINIC 0.325636 60 0 0 20 90.00 91.00 09100 EMERGENCY 0.325636 60 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.677501 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0 0</td><td>-</td><td></td></t<>						0 0	-	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 544184 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 439113 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 380874 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 427762 0 0 205 0 73. 00 76. 00 03020 ONCOLOGY 0. 753228 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 538690 0 0 0 76. 07 001700 UTPATI ENT SERVICE COST CENTERS 0. 325636 60 0 0 0 90. 00 90. 00 09100 EMERGENCY 0. 325636 60 0 0 0 91. 00 91. 00 09100 EMERGENCY 0. 325636 60 0 0 92. 00 92. 00						0 0	-	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.439113 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.380874 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.427762 0 0 205 0 73.00 76.00 03020 ONCOLOGY 0.753228 0 0 0 0 0 76.00 76.97 CARDIAC REHABILITATION 0.538690 0 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 0.325636 60 0 0 0 90.00 90.00 09000 CLINIC 0.325636 60 0 0 90.00 91.00 09100 EMERGENCY 0.220432 0 0 0 92.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0.677501 0 0 0 92.00 200.00 Subtotal (see instructions) </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0 0</td> <td></td> <td></td>						0 0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.380874 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.427762 0 0 205 0 73.00 76.00 03020 ONCOLOGY 0.753228 0 0 0 0 76.00 76.97 07697 CARDIAC REHABILITATION 0.538690 0 0 0 0 76.97 0000 00000 CLINIC 0.325636 60 0 0 0 90.00 90.00 09100 EMERGENCY 0.325636 60 0 0 90.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.677501 0 0 92.00 92.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00						0 0	-	
73.00 07300 DRUGS CHARGED TO PATIENTS 0.427762 0 0 205 0 73.00 76.00 03020 ONCOLOGY 0.753228 0 0 0 0 76.00 76.97 07697 CARDI AC REHABILITATION 0.538690 0 0 0 0 76.97 000 0000 CLINIC 0.325636 60 0 0 205 90.00 90.00 09100 EMERGENCY 0.325636 60 0 0 90.00 91.00 92.00 0 0 0 92.00 92.00 0 0 0 92.00 92.00 0 0 0 92.00 92.00 0 0 0 92.00 92.00 0 0 0 92.00 92.00 92.00 92.00 92.00 0 0 0 92.00 92.00 92.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00						0 0	-	
76.00 03020 ONCOLOGY 0.753228 0 0 0 0 76.00 76.97 07697 CARDI AC_REHABILITATION 0.538690 0 0 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0.325636 60 0 0 20 90.00 90.00 09100 EMERGENCY 0.325636 60 0 0 91.00 92.00 0 0 0 91.00 92.00 0 0 0 92.00 9200 085ERVATION BEDS (NON-DISTINCT PART 0.677501 0 0 0 92.00 92.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>0 205</td><td>-</td><td></td></td<>						0 205	-	
76. 97 07697 CARDI AC REHABILITATION 0.538690 0 0 0 76. 97 0UTPATI ENT SERVICE COST CENTERS 90. 00 0 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 91. 00 92. 00 0 0 0 92. 00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td></t<>							-	
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0.325636 60 0 20 90.00 91.00 09100 EMERGENCY 0.220432 0 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.677501 0 0 0 92.00 200.00 Subtotal (see instructions) 60 0 205 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00							-	
90. 00 09000 CLINIC 0. 325636 60 0 20 90. 00 91. 00 09100 EMERGENCY 0. 220432 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 677501 0 0 0 92. 00 200. 00 Subtotal (see instructions) 60 0 205 20 200. 00 201. 00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201. 00			0. 538690	0	<u> </u>	0 0	0	/0.9/
91.00 09100 EMERGENCY 0.220432 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.677501 0 0 0 92.00 200.00 Subtotal (see instructions) 60 0 205 20 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00			0 225626	60		0	20	00.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0. 677501 0 0 0 92. 00 200. 00 Subtotal (see instructions) 60 0 205 20 200. 00 201. 00 Less PBP Clinic Lab. Services-Program Only Charges 60 0 0 201. 00								
200.00Subtotal (see instructions)60020520200.00201.00Less PBP Clinic Lab. Services-Program00201.000nl y Charges00201.00								
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges 0 0 201.00			0.077501				Ű	
Only Charges				60			20	
	201.00					0		201.00
	202.00			60		0 205	20	202.00

Health Financial Systems	JOHNSON MEMOR	I AL_HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider Concernent	CN: 15-0001 CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pro 1/16/2018 2:	epared: 52 pm
		Title	e XVIII	Subprovider - IRF	PPS	
	Co	sts				
Cost Center Description	Cost Reimbursed Services Subject To	Cost Reimbursed Services Not Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS			1			
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0	0				50.00 53.00
54. 00 05400 RADI OLOGY -DI AGNOSTI C						53.00
60. 00 06000 LABORATORY						60.00
65. 00 06500 RESPIRATORY THERAPY						65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY		Ö				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	88				73.00
76.00 03020 ONCOLOGY	0	0				76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76.97
0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC		0				90.00
90. 00 109000 CET NTC 91. 00 09100 EMERGENCY						90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
200.00 Subtotal (see instructions)		88				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
0nly Charges 202.00 Net Charges (line 200 +/- line 201)	C	88				202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 1/16/2018 2:5	
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			l			
50. 00 05000 OPERATI NG ROOM	0. 220964	0	465, 55		0	
53. 00 05300 ANESTHESI OLOGY	0. 043806	0	45, 26		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 158988	0	647, 10		0	
60. 00 06000 LABORATORY	0. 189878	0	378, 68		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 336191	0	38, 12		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 407166	0	26, 99		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 216175	0	54, 81		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 319742	0	39, 90	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 209131	0	42, 98	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 544184	0	2, 21	4 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 439113	0	174, 61	7 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 380874	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 427762	0	176, 13	1 0	0	73.00
76.00 03020 ONCOLOGY	0. 753228	0	6, 69	6 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 538690	0	86	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 325636	0	22, 64	2 0	0	90.00
91.00 09100 EMERGENCY	0. 220432	0	670, 49	8 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 677501	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0	2, 793, 08	4 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	2, 793, 08	4 0	0	202.00

Heal th Fi	nancial Systems	JOHNSON MEMOR	IAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI O	NMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Peri od: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 1/16/2018 2:5	
				e XIX	Hospi tal	Cost	
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ICI LLARY SERVI CE COST CENTERS	102.070	0				50.00
	5000 OPERATING ROOM	102, 870					50.00
	5300 ANESTHESI OLOGY	1, 983					53.00
	5400 RADI OLOGY-DI AGNOSTI C	102, 882					54.00
		71, 903					60.00
	5500 RESPIRATORY THERAPY	12, 818					65.00
	600 PHYSI CAL THERAPY	10, 993					66.00
	5700 OCCUPATI ONAL THERAPY	11, 849					67.00
	5800 SPEECH PATHOLOGY	12, 758					68.00
	900 ELECTROCARDI OLOGY	8, 988					69.00
	7000 ELECTROENCEPHALOGRAPHY	1, 205					70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	76, 677					71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	-				72.00
	300 DRUGS CHARGED TO PATIENTS	75, 342					73.00
	3020 ONCOLOGY	5,044					76.00
	7697 CARDI AC REHABI LI TATI ON	463	0				76.97
	ITPATIENT SERVICE COST CENTERS	1	1				-
	2000 CLINIC	7,373					90.00
	P100 EMERGENCY	147, 799					91.00
	2200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
200.00	Subtotal (see instructions)	650, 947	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	650, 947	0				202.00

	Financial Systems JOHNSON MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2015 To 12/31/2015	Date/Time Pre	narc
				1/16/2018 2:5	
	Cost Conton Desprintion	Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
~~	INPATIENT DAYS			F F0F	1 1
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			5, 595 5, 595	1
00	Private room days (excluding swing-bed and observation bed day		rivate room davs	5, 545	3
00	do not complete this line.		i vato i com dajo,	C C	
00	Semi-private room days (excluding swing-bed and observation be			4, 702	4
00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decemb	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)			0	
00	Total swing-bed NF type inpatient days (including private room	m days) through Decembe	r 31 of the cost	0	7
~~	reporting period				
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December	al of the cost	0	8
00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	2, 448	9
	newborn days)	Ç .			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of		coom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	' '
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
~~	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XL after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)		5 .	0	15
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost	0.00	1 17
. 00	reporting period	es through becember 31	on the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 o	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service:	s after December 31 of	the cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction			6, 653, 132	
. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	er 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	na period (line 6	0	23
	x line 18)	·	5 T X		
. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost report	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	n period (line 8	0	25
. 00	x line 20)			0	20
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 653, 132	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had a	arranc)	0	1 20
	Private room charges (excluding swing-bed charges)	d and observation bed ch	lai yes)	0	28 29
	Semi-private room charges (excluding swing bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	rtions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin	, ,	50101137	0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	fferential (line	6, 653, 132	37
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see			1, 189. 12	38
. 00	Program general inpatient routine service cost (line 9 x line	38)		2, 910, 966	39
	Medically necessary private room cost applicable to the Progra			0	40
()()	Total Program general inpatient routine service cost (line 39	+ IINE 40)		2, 910, 966	1 41

MPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2015	Worksheet D-1	1
				To 12/31/2015	Date/Time Pre 1/16/2018 2:5	
			XVIII	Hospi tal	PPS	
Cost Center Description	Total Inpatient Costl	Total npatient Days		Program Days	(col. 3 x col.	
	1.00	2.00	col. 2) 3.00	4.00	4)	+
2.00 NURSERY (title V & XIX only)	0	0) 42.
Intensive Care Type Inpatient Hospital Uni		0.05	0.404.0	(05((00.0/0	1 10
B. OO INTENSIVE CARE UNIT 1. OO CORONARY CARE UNIT	2, 278, 561	935	2, 436. 9	6 256	623, 862	2 43.
. 00 BURN INTENSIVE CARE UNIT						45.
. 00 SURGI CAL I NTENSI VE CARE UNI T						46.
0 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3,	line 200)			3, 768, 536	6 48
0.00 Total Program inpatient costs (sum of line	s 41 through 48)(s	ee instructio	ns)		7, 303, 364	49.
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program i	nnationt routine s	ervices (from	West D sum	of Parts 1 and	361, 038	3 50.
	ilpatrent routine s		WKST. D, Sum		301,030	5 50.
.00 Pass through costs applicable to Program i	npatient ancillary	services (fr	om Wkst. D, s	um of Parts II	242, 914	¥ 51.
and IV) 2.00 Total Program excludable cost (sum of line	s 50 and 51)				603, 952	2 52.
8.00 Total Program inpatient operating cost exc		ated, non-phy	sician anesth	etist, and	6, 699, 412	
medical education costs (line 49 minus lin						
TARGET AMOUNT AND LIMIT COMPUTATION						
1.00 Program discharges 5.00 Target amount per discharge					0.00	
5.00 Target amount (line 54 x line 55)					C	
.00 Difference between adjusted inpatient oper	ating cost and tar	get amount (I	ine 56 minus	line 53)	C	
B. 00 Bonus payment (see instructions)	mounded by the					
0.00 Lesser of lines 53/54 or 55 from the cost market basket	ipounded by the	0.00	J 59			
0.00 Lesser of lines 53/54 or 55 from prior yea					0.00	60
.00 If line 53/54 is less than the lower of li					C	61
which operating costs (line 53) are less t amount (line 56), otherwise enter zero (se		(TThes 54 x	60), or 1% or	the target		
2.00 Relief payment (see instructions)					C	62.
8.00 Allowable Inpatient cost plus incentive pa	yment (see instruc	tions)			C) 63.
PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine c	osts through Decem	her 31 of the	cost reporti	na period (See	C	64.
instructions) (title XVIII only)	osts through becom					
6.00 Medicare swing-bed SNF inpatient routine of	osts after Decembe	r 31 of the c	ost reporting	period (See	C	65.
instructions)(title XVIII only) 0.00 Total Medicare swing-bed SNF inpatient rou	tine costs (line 6	1 nlus line 6	5)(title XV/II	lonly) For	c c) 66.
CAH (see instructions)				i oniy). Toi		
2.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 c	f the cost re	porting period	C	67.
(line 12 x line 19) B.OO Title V or XIX swing-bed NF inpatient rout	ing costs after Do	combor 21 of	the cost rope	rting poriod	C	68.
(line 13 x line 20)	The costs after be		the cost repo	ting period		00.
0.00 Total title V or XIX swing-bed NF inpatier					C	69.
PART III - SKILLED NURSING FACILITY, OTHER						1 70
 0.00 Skilled nursing facility/other nursing fac .00 Adjusted general inpatient routine service 	5		• • •			70
2.00 Program routine service cost (line 9 x lin						72
8.00 Medically necessary private room cost appl						73
4.00 Total Program general inpatient routine set 5.00 Capital-related cost allocated to inpatien				art II column		74
6.00 Capital-related cost allocated to inpatien 26, line 45)	LI TOULTHE SELVICE		UNSHEEL D, P	art II, CULUMNI		/ 5
0.00 Per diem capital-related costs (line 75 ÷						76
2.00 Program capital-related costs (line 9 x li						77
.00 Inpatient routine service cost (line 74 mi .00 Aggregate charges to beneficiaries for exc		ovider record	s)			78
.00 Total Program routine service costs for co				us line 79)		80
.00 Inpatient routine service cost per diem li						81
 .00 Inpatient routine service cost limitation .00 Reasonable inpatient routine service costs 	• • •					82
 .00 Reasonable inpatient routine service costs .00 Program inpatient ancillary services (see)				83
5.00 Utilization review - physician compensatio		s)				85
0.00 Total Program inpatient operating costs (s		ough 85)				86
PART IV - COMPUTATION OF OBSERVATION BED P 7.00 Total observation bed days (see instruction					893	3 87
8.00 Adjusted general inpatient routine cost pe		line 2)			1, 189. 12	
	see instructions)	-			1, 061, 884	

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 1/16/2018 2:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	738, 757	6, 653, 132	0. 11103	9 1, 061, 884	117, 911	90.00
91.00 Nursing School cost	0	6, 653, 132	0.00000	0 1, 061, 884	0	91.00
92.00 Allied health cost	0	6, 653, 132	0.00000	0 1, 061, 884	0	92.00
93.00 All other Medical Education	0	6, 653, 132	0.00000	0 1, 061, 884	0	93.00

	Financial Systems JOHNSON MEMORIAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T001	From 01/01/2015 To 12/31/2015	Date/Time Pre 1/16/2018 2:53	
		Title XVIII	Subprovider -	PPS	2 pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS		I	1100	
	I NPATI ENT DAYS				
. 00	Inpatient days (including private room days and swing-bed days			1, 191	1.
. 00	Inpatient days (including private room days, excluding swing-			1, 191	2.
. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		1, 191	4.
00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	5.
	reporting period			-	
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7.
00	reporting period Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)	i days) al ter becenber 3	in on the cost	0	0.
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	503	9.
	newborn days)		U U		
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10.
1 00	through December 31 of the cost reporting period (see instruct			0	1 1 1
1.00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		com days) arter	0	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.
2.00	through December 31 of the cost reporting period		c room days)	0	12.
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX	K only (including privat	e room days)	0	13.
	after December 31 of the cost reporting period (if calendar ye				
1.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.
	Total nursery days (title V or XIX only)			0	15.
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.
7.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17
	reporting period	ss through becomen of a		0.00	
3. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19.
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.
5.00	reporting period	Sarter December 31 01 t	ne cost	0.00	20.
1.00	Total general inpatient routine service cost (see instructions	5)		1, 614, 347	21.
2.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22.
	5 x line 17)				
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	g period (line 6	0	23.
4.00	x line 18) Swing-bed cost applicable to NF type services through December	a 31 of the cost reporti	ng period (line	0	24.
+. 00	7 x line 19)	ST OF THE COST TEPOLT	ng period (inne	0	24.
5.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.
	x line 20)				
	Total swing-bed cost (see instructions)			0	26.
6.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 614, 347	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abcomuction had a	07700)	0	28.
7.00			lai yes)	0	1 20.
7.00 3.00	General inpatient routine service charges (excluding swing-bed		1		
7.00 3.00 9.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)			0	29.
2.00 3.00 9.00 9.00	General inpatient routine service charges (excluding swing-bed			0 0.000000	29. 30.
. 00 . 00 . 00 . 00 . 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 30. 31.
 00 0	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	÷line 28)		0 0. 000000 0. 00 0. 00	29. 30. 31. 32. 33.
7.00 3.00 9.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min	÷line 28) nus line 33)(see instruc	tions)	0 0. 000000 0. 00 0. 00 0. 00	29. 30. 31. 32. 33. 34.
7.00 3.00 9.00 9.00 1.00 2.00 3.00 4.00 5.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x lin Average per diem private room cost differential (line 34 x lin	÷line 28) nus line 33)(see instruc	ti ons)	0 0. 000000 0. 00 0. 00 0. 00 0. 00	29. 30. 31. 32. 33. 34. 35.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	⊦line 28) nus line 33)(see instruc ne 31)		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	29. 30. 31. 32. 33. 34. 35. 36.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	⊦line 28) nus line 33)(see instruc ne 31)		0 0. 000000 0. 00 0. 00 0. 00 0. 00	29. 30. 31. 32. 33. 34. 35. 36.
7.00 8.00 9.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	⊦line 28) nus line 33)(see instruc ne 31)		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	29. 30. 31. 32. 33. 34. 35. 36.
7.00 3.00 9.00 <t< td=""><td>General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY</td><td>÷ line 28) nus line 33)(see instruc ne 31) and private room cost di</td><td></td><td>0 0. 000000 0. 00 0. 00 0. 00 0. 00 0</td><td>29. 30. 31. 32. 33. 34. 35. 36.</td></t<>	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	÷ line 28) nus line 33)(see instruc ne 31) and private room cost di		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	29. 30. 31. 32. 33. 34. 35. 36.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 5.00 7.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	÷ line 28) nus line 33)(see instruc ne 31) and private room cost di JSTMENTS		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	29. 30. 31. 32. 33. 34. 35. 36. 37.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	÷ line 28) nus line 33)(see instruc ne 31) and private room cost di JSTMENTS instructions)		0 0. 000000 0. 00 0. 00 0. 00 0 1, 614, 347	29. 30. 31. 32. 33. 34. 35. 36. 37. 38.
7.00 3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 5.00 7.00 3.00 9.00 0.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	<pre> F line 28) hus line 33)(see instruct he 31) and private room cost di JSTMENTS instructions) 38) am (line 14 x line 35)</pre>		0 0. 000000 0. 00 0. 00 0. 00 0 1, 614, 347 1, 355. 46	29 30 31 32 33 34 35 36 37 38 39 40

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST	JOHNSON MEMORIAL	Provider C	CN: 15-0001	Period:	eu of Form CMS- Worksheet D-1	
			CCN: 15-T001	From 01/01/2015 To 12/31/2015	Date/Time Pre	epare
		Ti tl e	e XVIII	Subprovider - IRF	1/16/2018 2:5 PPS	52 pm
Cost Center Description	Total Inpatient CostIn	Total patient Days		Program Days	Program Cost (col. 3 x col.	
	1.00	2.00	col. 2) 3.00	4.00	4) 5.00	-
.00 NURSERY (title V & XIX only)	0	C) 42.
Intensive Care Type Inpatient Hospital Uni . 00 INTENSIVE CARE UNIT	ts		0.	00000	0) 43.
. 00 CORONARY CARE UNIT	0	C	0.	00 0		44
. OO BURN INTENSIVE CARE UNIT						45
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
2.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
.00 Program inpatient ancillary service cost (What D-3 col 3	Line 200)			1.00 261,417	7 48
00 Total Program inpatient costs (sum of line			ons)		943, 213	
PASS THROUGH COST ADJUSTMENTS						
0.00 Pass through costs applicable to Program i	npatient routine se	rvices (from	n Wkst. D, su	n of Parts I and	68, 639	9 50
.00 Pass through costs applicable to Program i	npatient ancillary	services (fr	om Wkst. D,	sum of Parts II	14, 177	51
and IV)						
2.00 Total Program excludable cost (sum of line 3.00 Total Program inpatient operating cost exc		ted non-nh	vsician anest	notist and	82, 816 860, 397	
medical education costs (line 49 minus lin					000, 347	
TARGET AMOUNT AND LIMIT COMPUTATION					0	54
. 00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					0	
 .00 Difference between adjusted inpatient oper .00 Bonus payment (see instructions) 	ating cost and targ	et amount (I	ine 56 minus	line 53)		
. 00 Lesser of lines 53/54 or 55 from the cost	reporting period en	ding 1996, ι	updated and c	ompounded by the		
market basket						
0.00 Lesser of lines 53/54 or 55 from prior yea 1.00 If line 53/54 is less than the lower of li				the amount by	0.00	
which operating costs (line 53) are less t						101
amount (line 56), otherwise enter zero (se	e instructions)					
2.00 Relief payment (see instructions) 2.00 Allowable Inpatient cost plus incentive pa	ivment (see instruct	ions)				
PROGRAM INPATIENT ROUTINE SWING BED COST	· ·					
.00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	costs through Decemb	er 31 of the	e cost report	ng period (See	0	64
. 00 Medicare swing-bed SNF inpatient routine of	osts after December	31 of the c	ost reportin	g period (See	0	65
instructions)(title XVIII only)						
 00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions) 	itine costs (line 64	plus line 6	5)(title XVI	II only). For	C) 66
7.00 Title V or XIX swing-bed NF inpatient rout	ine costs through D	ecember 31 c	of the cost re	eporting period	0	67
(line 12 x line 19)	ina agata aftar Dag	ombor 21 of	the east rep	arting pariod		
3.00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	The costs after Dec		the cost rep	bring period	C	68
0.00 Total title V or XIX swing-bed NF inpatier	,				0) 69
PART III - SKILLED NURSING FACILITY, OTHER 0.00 Skilled nursing facility/other nursing fac)		70
. 00 Adjusted general inpatient routine service	5			, ,		71
.00 Program routine service cost (line 9 x lin	· · ·		25)			72
.00 Medically necessary private room cost appl .00 Total Program general inpatient routine se	ι,					73
.00 Capital-related cost allocated to inpatier	•			Part II, column		75
26, line 45) .00 Per diem capital-related costs (line 75 ÷	line 2)					76
.00 Program capital-related costs (line 9 x li						77
 .00 Inpatient routine service cost (line 74 mi .00 Aggregate charges to beneficiaries for exc 		vider record	ls)			78
.00 Total Program routine service costs for co				nus line 79)		80
.00 Inpatient routine service cost per diem li	mitation			~		81
. 00 Inpatient routine service cost limitation	• • •					82
 00 Reasonable inpatient routine service costs 00 Program inpatient ancillary services (see 						83
0.00 Utilization review - physician compensatio)				85
00 Total Program inpatient operating costs (s		ugh 85)				86
PART IV - COMPUTATION OF OBSERVATION BED P 7.00 Total observation bed days (see instruction					C	87
8.00 Adjusted general inpatient routine cost pe		ine 2)			0.00	
0.00 Observation bed cost (line 87 x line 88) (89

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2015	Worksheet D-1	
		Component (To 12/31/2015		pared: 2 pm
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	162, 518	1, 614, 347	0. 10067	'1 0	0	90.00
91.00 Nursing School cost	0	1, 614, 347	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 614, 347	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 614, 347	0.00000	0 0	0	93.00

MPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015		pare
		Title XIX	Hospi tal	1/16/2018 2:5 Cost	2 pn
	Cost Center Description		nospi tui		
	PART I - ALL PROVIDER COMPONENTS			1.00	
[INPATI ENT DAYS				
	Inpatient days (including private room days and swing-bed day: Inpatient days (including private room days, excluding swing-			5, 595 5, 595	
	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	3
	do not complete this line.		-	4 700	
	Semi-private room days (excluding swing-bed and observation by Total swing-bed SNF type inpatient days (including private roo	5 /	er 31 of the cost	4, 702 0	4
	reporting period				
00	Total swing-bed SNF type inpatient days (including private rom reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	- 31 of the cost	0	7
	reporting period			0	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December s	31 OF THE COST	0	8
00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	132	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	coom dave)	0	10
00	through December 31 of the cost reporting period (see instruct		com days)	0	
	Swing-bed SNF type inpatient days applicable to title XVIII or		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI.		te room days)	0	12
	through December 31 of the cost reporting period	<u> </u>	<u> </u>		
	Swing-bed NF type inpatient days applicable to titles V or XL after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progra			0	14
00	Total nursery days (title V or XIX only)			650	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			18	16
	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17
00	reporting period Madiagana mata fan awing had SNE gamuiaga annligshia ta gamuia	an aftar December 21 of	the east	0.00	10
00	Medicare rate for swing-bed SNF services applicable to service reporting period	es alter becember 31 01	the cost	0.00	
00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19
00	reporting period Medicaid rate for swing-bed NF services applicable to service:	s after December 31 of 1	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through Decemb	·	ting pariod (line	6, 653, 132 0	21
00	5 x line 17)	el 31 Ul the cost report	ting period (inie	0	
	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24
	7 x line 19)		0 1 1		
	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	g period (line 8	0	25
	Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 653, 132	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28
00	Private room charges (excluding swing-bed charges)		5.00	0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	· line 28)		0 0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		ctions)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	6, 653, 132	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
Į	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
	Adjusted general inpatient routine service cost per diem (see			1, 189. 12	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	-		156, 964 0	39
	Total Program general inpatient routine service cost (line 39			156, 964	

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0001	Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2015 To 12/31/2015		
			Titl	e XIX	Hospi tal	1/16/2018 2:5 Cost	52 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient CostI	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	344, 373	650	529.	30 18	9, 536	42.
8. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	2, 278, 561	935	2, 436,	26	63, 361	43.
1.00	CORONARY CARE UNI T				-		44.
5.00	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.
	Cost Center Description						
00	Program inpatient ancillary service cost (Wks		Line 200)			1.00 144,986	10
. 00 . 00	Total Program inpatient costs (sum of lines 4			ns)		374, 847	
	PASS THROUGH COST ADJUSTMENTS			*			
0. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	0	50.
. 00	III) Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51.
	and IV)						
2.00 3.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		ated non-nhy	sician anest	patist and	0 0	
5.00	medical education costs (line 49 minus line !		ated, non-phy				, 55.
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
3.00 9.00	Bonus payment (see instructions)	mounded by the	0.00				
. 00	0 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
0.00	Lesser of lines 53/54 or 55 from prior year of					0.00	
1.00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61
	amount (line 56), otherwise enter zero (see i		(<u>-</u> <u>-</u>		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ont (coo instruc	tionc)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	or 31 of the c	ost reportin	n period (See	0	65.
. 00	instructions) (title XVIII only)	ts arter becembe			g period (See		/ 03.
6.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line 6	5)(title XVI	l only). For	0	66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	eporting period	0	67
	(line 12 x line 19)	0					
3. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68.
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (I	ine 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY			
). 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	5					70
. 00	Program routine service cost (line 9 x line			2)			72
. 00	Medically necessary private room cost applica	0	•				73
. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i	•			Part II column		74
. 00	26, line 45)	foutifie service		or Kaneet D, I			'
. 00	Per diem capital-related costs (line 75 ÷ lin						76
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
. 00	Aggregate charges to beneficiaries for excess		ovider record	s)			79
. 00	Total Program routine service costs for compa		st limitation	(line 78 min	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li						81
. 00	Reasonable inpatient routine service cost (83
. 00	Program inpatient ancillary services (see in	structions)					84
5.00 5.00	Utilization review - physician compensation Total Program inpatient operating costs (sum					1	85
,. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS						- 00
7.00	Total observation bed days (see instructions))				893	
3.00	Adjusted general inpatient routine cost per o					1, 189. 12	1 00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 1/16/2018 2:5	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	738, 757	6, 653, 132	0. 11103	9 1, 061, 884	117, 911	90.00
91.00 Nursing School cost	0	6, 653, 132	0.00000	0 1, 061, 884	0	91.00
92.00 Allied health cost	0	6, 653, 132	0.00000	0 1, 061, 884	0	92.00
93.00 All other Medical Education	0	6, 653, 132	0.00000	0 1, 061, 884	0	93.00

	Financial Systems JOHNSON MEMORIA ATION OF INPATIENT OPERATING COST JOHNSON J	Provider CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet D-1	
		Component CCN: 15-T001	From 01/01/2015 To 12/31/2015	Date/Time Prep 1/16/2018 2:52	
		Title XIX	Subprovider - IRF	Cost	2 pm
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		l		
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs oveluding nowhern)		1, 191	1.
00	Inpatient days (including private room days, excluding swing-bed da			1, 191	2.
00	Private room days (excluding swing-bed and observation bed d	5,	ivate room days,	0	
	do not complete this line.	5, 5, 5, 5,	J .		
00	Semi-private room days (excluding swing-bed and observation	5 /		1, 191	4
00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decembe	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	com days) arter becember	ST OF the cost	0	
00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	0	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private ro	om days) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	swing_bed_and	31	9
00	newborn days)		J Swilly bed and	51	'
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	room days)	0	10
	through December 31 of the cost reporting period (see instru				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12
. 00	through December 31 of the cost reporting period	in only (menduring privat	e room days)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar				
. 00	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	0	
. 00 . 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			650 18	15 16
. 00	SWING BED ADJUSTMENT		l	10	
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 c	of the cost	0.00	17
~~~	reporting period			0.00	
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost	0.00	81
. 00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	f the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	the cost	0.00	20
00	reporting period			1 (14 )47	21
. 00	Total general inpatient routine service cost (see instructio Swing-bed cost applicable to SNF type services through Decem		ing period (line	1, 614, 347 0	21
. 00	5 x line 17)	bel 31 01 the cost report	ing period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reportir	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25
. 00	x line 20)		, per lou (l'llie o	0	20
b. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		1, 614, 347	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ad and abcomunition had ak		0	20
. 00 . 00	Private room charges (excluding swing-bed charges)	ed and observation bed ci	lai yes)	0	28 29
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)		stions)	0.00	
. 00	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
. 00	General inpatient routine service cost net of swing-bed cost		fferential (line	1, 614, 347	
. 00 . 00	beneral inpatrent roatine service cost net of sming bed cost				
. 00 . 00	27 minus line 36)				1
. 00 . 00	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	HIGTMENTS			
. 00 . 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			1 255 14	20
. 00 . 00 . 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD Adjusted general inpatient routine service cost per diem (se	e instructions)		1, 355. 46 42, 019	
5. 00 5. 00 7. 00 7. 00 8. 00 9. 00 9. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	e instructions) e 38)		1, 355. 46 42, 019 0	38 39 40

	inancial Systems ION OF INPATIENT OPERATING COST	JOHNSON MEMORIAL	HOSPITAL Provider C	CN: 15-0001	In Lie Period:	eu of Form CMS- Worksheet D-1	
				CCN: 15-T001	From 01/01/2015 To 12/31/2015		epare
			Ti tl	e XIX	Subprovider -	Cost	JZ pii
	Cost Center Description	Total Inpatient CostIn	Total patient Days			Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
	URSERY (title V & XIX only)	0	C	0.	00 0	C	) 42.
	ntensive Care Type Inpatient Hospital Units NTENSIVE CARE UNIT	0		0.	00 0		) 43.
	CORONARY CARE UNIT						44.
	SURN INTENSIVE CARE UNIT						45.
	SURGI CAL INTENSI VE CARE UNI T ITHER SPECI AL CARE (SPECI FY)						46.
	Cost Center Description					1.00	
. 00 P	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			1.00	7 48
	otal Program inpatient costs (sum of lines	41 through 48)(se	e instructio	ons)		45, 966	5 49
	ASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine se	rvices (from	n Wkst. D, su	m of Parts I and	C	50
1	11)						
	vass through costs applicable to Program inpa Ind IV)	atient ancillary	services (fr	um wkst. D,	sum or Parts II	C	51
. 00 T	otal Program excludable cost (sum of lines !					C	
m	otal Program inpatient operating cost exclud Medical education costs (line 49 minus line ! ARGET AMOUNT AND LIMIT COMPUTATION		ited, non-phy	vsician anest	hetist, and	C	) 53
. 00 P	Program discharges					C	
	arget amount per discharge arget amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operati	ing cost and targ	et amount (I	ine 56 minus	line 53)	C	
	Bonus payment (see instructions)	onting pariod on	ding 100/	indated and a	ampounded by the	0 00	
	esser of lines 53/54 or 55 from the cost rep market basket	borting period en	idi ng 1996, it	ipuated and c	ompounded by the	0.00	) 59
. 00   I   w	esser of lines 53/54 or 55 from prior year of f line 53/54 is less than the lower of lines which operating costs (line 53) are less that mount (line 56), otherwise enter zero (see i	s 55, 59 or 60 en n expected costs	iter the less	er of 50% of	the amount by	0. 00 C	
. 00 R . 00 A	elief payment (see instructions) Nlowable Inpatient cost plus incentive payme		i ons)				
	ROGRAM INPATIENT ROUTINE SWING BED COST ledicare swing-bed SNF inpatient routine cos ⁻	ts through Decemb	er 31 of the	e cost report	ing period (See	C C	64
i	nstructions)(title XVIII only)						
	<pre>ledicare swing-bed SNF inpatient routine cos nstructions)(title XVIII only)</pre>	ts arter December	31 of the c	ost reportin	g period (See	C	) 65
. 00 T	otal Medicare swing-bed SNF inpatient routin AH (see instructions)	ne costs (line 64	plus line 6	o5)(title XVI	II only). For	C	66
. 00 T	itle V or XIX swing-bed NF inpatient routine	e costs through D	ecember 31 d	of the cost r	eporting period	C	67
. 00 T	line 12 x line 19) Title V or XIX swing-bed NF inpatient routine Ving 12 x line 20)	e costs after Dec	ember 31 of	the cost rep	orting period	C	68
. 00 <u>T</u>	line 13 x line 20) otal title V or XIX swing-bed NF inpatient i					c	69
	ART III - SKILLED NURSING FACILITY, OTHER NU ikilled nursing facility/other nursing facili				)		70
. 00 A	djusted general inpatient routine service co	ost per diem (lin					71
1	Program routine service cost (line 9 x line Nedically necessary private room cost applica		line 14 v H	ne 35)			72
	otal Program general inpatient routine servi	0 .					74
2	Capital-related cost allocated to inpatient ( 6, line 45)		osts (from V	lorksheet B,	Part II, column		75
	?er diem capital-related costs (line 75 ÷ lin ?rogram capital-related costs (line 9 x line						76
00 1	npatient routine service cost (line 74 minus	s line 77)					78
	ggregate charges to beneficiaries for excess otal Program routine service costs for compa	• •			nus line 70)		80
1	npatient routine service cost per diem limi		it i i mitati Of	י (יייש ווו	nus IIIE /7)		80
. 00	npatient routine service cost limitation (li	ne 9 x line 81)					82
	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in						83
	Itilization review - physician compensation		.)				84
. 00 T	otal Program inpatient operating costs (sum	of lines 83 thro					86
	ART IV - COMPUTATION OF OBSERVATION BED PASS otal observation bed days (see instructions)					c	87
	djusted general inpatient routine cost per d		ine 2)			0.00	
I	bservation bed cost (line 87 x line 88) (see	e instructions)				1 0	89

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2015	Worksheet D-1	
		Component (		To 12/31/2015	Date/Time Pre 1/16/2018 2:5	pared: 2 pm
		Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	162, 518	1, 614, 347	0. 10067	1 0	0	90.00
91.00 Nursing School cost	0	1, 614, 347	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	1, 614, 347	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	1, 614, 347	0.00000	0 0	0	93.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0001	Peri od:	Worksheet D-3	
				From 01/01/2015	Data (Time Dres	
				To 12/31/2015	Date/Time Pre 1/16/2018 2:5	
		Title	e XVIII	Hospi tal	PPS	2 pm
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				0.00(.00(		00.00
30. 00 03000 ADULTS & PEDIATRICS				3, 236, 896		30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF				518, 427		31.00
41.00  04100  SUBPROVIDER - TRF 43.00  04300  NURSERY				0		41.00 43.00
ANCI LLARY SERVICE COST CENTERS						43.00
50. 00 05000 OPERATING ROOM			0. 2209	2, 064, 798	456, 246	50.00
53. 00 05300 ANESTHESI OLOGY			0. 04380			
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 1589		, s	
60. 00 06000 LABORATORY			0, 1898			
65. 00 06500 RESPI RATORY THERAPY			0. 3361			•
66. 00 06600 PHYSI CAL THERAPY			0. 4071			66.00
67.00 06700 OCCUPATIONAL THERAPY			0. 2161	75 228, 211	49, 334	67.00
68.00 06800 SPEECH PATHOLOGY			0. 3197	42 61, 752	19, 745	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 2091	31 741, 863	155, 147	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 54418		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 4391		742, 749	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 3808		0	
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 4277			•
76.00 03020 ONCOLOGY			0. 7532		0	
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 5386	90 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C			0. 3256			
91.00 09100 EMERGENCY			0. 22043			•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0.67750			•
200.00 Total (sum of lines 50 through 94 and 9		(1) 00 (1)		13, 458, 865		
201.00 Less PBP Clinic Laboratory Services-Pro 202.00 Net charges (line 200 minus line 201)	ogram onry charges	(The 61)		12 459 945		201.00
202.00 Net charges (line 200 minus line 201)			I	13, 458, 865	I	202.00

Health Financial Systems JOHNSON MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-0001	Peri od:	Worksheet D-3	3
	Component (	CCN: 15-T001	From 01/01/2015 To 12/31/2015		narod
	component c	CN. 15-1001	10 12/31/2015	1/16/2018 2:5	
	Title	XVIII	Subprovider -	PPS	
			I RF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	9	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS			C	1	30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
41. 00 04100 SUBPROVI DER - I RF			584, 756		41.00
43. 00 04300 NURSERY			001,700		43.00
ANCI LLARY SERVI CE COST CENTERS				1	
50. 00 05000 OPERATI NG ROOM		0. 2209	64 9, 909	2, 190	50.00
53. 00 05300 ANESTHESI OLOGY		0.0438	06 1, 196	52	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1589	88 21, 372	3, 398	54.00
60. 00 06000 LABORATORY		0. 1898	78 97, 736	18, 558	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 3361	91 25, 021	8, 412	65.00
66. 00 06600 PHYSI CAL THERAPY		0.4071	66 235, 640	95, 945	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2161	75 249, 626	53, 963	67.00
68.00 06800 SPEECH PATHOLOGY		0. 3197	42 96, 336	30, 803	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2091	31 6, 604	1, 381	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 5441		-	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 4391			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3808			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4277			
76. 00 03020 ONCOLOGY		0. 7532			
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 5386	90 C	0 0	76.97
OUTPATIENT SERVICE COST CENTERS		0.005/	a./		
90. 00 09000 CLINIC		0.3256			
91. 00 09100 EMERGENCY		0.2204		-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.6775			
200.00Total (sum of lines 50 through 94 and 96 through 98)201.00Less PBP Clinic Laboratory Services-Program only charges	(Lino (1)		841, 586		200.00
201.00Less PBP Clinic Laboratory Services-Program only charges202.00Net charges (line 200 minus line 201)	(inne or)		C 841, 586		201.00
zuz. uu jinet charges (Trhe zuu minus Trhe zur)			841,580	4	1202. UU

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         Provider CCN: 15-0001         Period: For 01/01/2012         Worksheet D-3 Date/Time Prepared: 17/16/2018 2:52 pm Date/Time Prepared: 17/16/2018 2:52 pm Provider COST Center Description         Worksheet D-3 Date/Time Prepared: 17/16/2018 2:52 pm Provider COST           INPATIENT ROUTINE SERVICE COST CENTERS         Inpatient Program Costs Cost Center Description         Inpatient Program Costs Cost Center Description         Inpatient Program Costs Cost Center Description           INPATIENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00           00         03000 ADULTS & PEDIATRICS         274, 633 31, 967         30.00           01         00         0100 INFROVIDER - IRF         31, 967         31.00           01         00         03000 ANDURSERY         0.220964         148, 731         32, 864           05:00         05000 CREDI NORTI OK ROM         0.220964         148, 731         77, 54.00           00         0.010 RID/CINPERVIDE DIAGOR         0.158988         10, 111         20, 908           00         0.02000 RESPI RATIORY THERAPY         0.336191 33, 458 110, 248         50.00           00         0.000 OCCL PATIONAL THERAPY	Health Financial Systems JO	HNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
To         12/31/2015         Date/Time Prepared: 1/16/2018         Date/Time Prepared: 1/2018           Impatient         Fitte XIX         Hospital         Cost           To         Charges         To         Charges         Cost           Impatient         Program         Cost         Inpatient         Program           0.00         03000         ADULTS & PEDIATRICS         3.00         3.00           30.00         03000         INTENSIVE CARE UNIT         31.00         31.00           41.00         O4100         SUBPROVIDER - IFF         0         0         43.00           ANCILLARY SERVICE COST CENTERS         0.220964         148, 731         32.864         50.00           53.00         OS3000 OPERATING ROM         0.220964         148, 731         32.864         50.00           65.00         OS000 OPERATING ROM         0.220964         148, 731         32.864         50.00           53.00         OS3000 ARESTRESI OLOGY         0.43806         21, 923         960         53.00           65.00         OBSON RESPI RATORY THERAPY         0.319742         1, 154         369         66.00           66.00         OBSON RESPI RATORY THERAPY         0.216175         3, 719         804         <	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider (	CCN: 15-0001		Worksheet D-3	
Intervention         Intervention<							
Interview         Title XIX         Hospital         Cost           Cost Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Costs (col. 1 x col. 2)           30.00         03000 ADULTS & PEDIATRICS         1.00         2.00         3.00           31.00         03100 (INTENS) VE CARE UNI T         31.967         31.00           43.00         04100 SUBBROVI DER - IRF         0         0         41.00           43.00         04300 NURSERY         0         224.633         31.06           50.00         05000 OPERATI NG ROM         0.220964         148.731         32.864         50.00           53.00         05000 OPERATI NG ROM         0.220964         148.731         32.864         50.00           54.00         05400 RADI OLOCY-DI AGNOSTI C         0.158978         10.111         20.908         60.00           65.00         06500 RESPI RATORY THERAPY         0.36191         33.458         11.248         65.00           66.00         06000 SPECH PATHORY THERAPY         0.36191         33.458         11.248         66.00           67.00         06700 OLLABORATORY         0.216175         3.719         80.4         67.00           68.00					10 12/31/2015		
INPATIENT ROUTINE SERVICE COST CENTERS         To Charges         Program Costs (col. 1 x col. 2)           30.00         03000 ADULTS & PEDIATRICS         30.00           31.00         31.967         31.00           31.00         03000 ADULTS & PEDIATRICS         31.967           31.00         03100 INTENSIVE CARE UNIT         31.967           41.00         04300 NURSERY         70,190           ANCILLARY SERVICE COST CENTERS         0.22064           50.00         05000 OPERATING ROOM         0.220964           30.00         0.03000 ADUSTSHEV         0.043806           60.00         06000 LABORATORY         0.189878           61.00         06500 RESPIRATING ROOM         0.220964           65.00         06500 RESPIRATORY         0.189878           66.00         06500 RESPIRATORY         0.36301           66.00         06500 RESPIRATORY         0.36311           66.00         06500 RESPIRATORY         0.319742           67.00         06000 SEECH RATINOK ROAPH         0.319742           68.00         06600 SEECH RATINOK         0.209131           69.00         0.0000 ELECTROCRARD IOLOGY         0.209131           71.00         71.00         71.00           72.00 <td< td=""><td></td><td></td><td>Ti t</td><td>le XIX</td><td>Hospi tal</td><td></td><td>2 piii</td></td<>			Ti t	le XIX	Hospi tal		2 piii
INPATI ENT ROUTI NE SERVI CE COST CENTERS         Charges         (col. 1 x col. 2)           1.00         2.00         3.00           30.00         03000 ADULTS & PEDI ATRICS         3.00           31.00         03100 INTENSI VE CARE UNIT         31.967           41.00         SUBPROVIDER - I RF         31.907           43.00         04300 NURSERY         70,190           ANCI LLARY SERVICE COST CENTERS         70,190           60.00         05000 (OPENATI NO ROOM         0.220964           61.00         148,731         32.864           62.00         05000 (OPENATI NO ROOM         0.220964           63.00         05000 (OPENATI NO ROOM         0.220964           64.00         6600 RM SOGO RADILOGY OF ARMONSTI C         0.189878           65.00         06500 RADICOGY OF ATARONY THERAPY         0.336191         33,458           66.00         06500 OPENSI CLA THERAPY         0.216175         3,719           67.00         06700 OCUPATI ONAL THERAPY         0.216175         3,719         844           67.00         06700 OELECTROCARDI OLOG	Cost Center Description			Ratio of Cos	t Inpatient	Inpatient	
INPATI ENT ROUTI NE SERVICE COST CENTERS         1.00         2.00         3.00           30.00         03000 ADULTS & PEDIATRI CS         274, 633         30.00           31.00         03100 INTENSIVE CARE UNI T         31, 967         31.00           41.00         04100 SUBPROVI DER - 1 RF         70, 190         41.00           43.00         05000 OPERATI NG ROOM         0.220964         148, 731         32, 864           50.00         05000 OPERATI NG ROOM         0.220964         148, 731         32, 864           50.00         05400 RADI OLOGY         0.43306 21, 923         966         53.00           53.00         05500 RSPI RATORY THERAPY         0.158988         48, 913         7, 777         54.00           66.00         06600 RSPI RATORY THERAPY         0.336191         33, 458         11.248         66.00           66.00         06600 RSPE RATORY THERAPY         0.317742         1, 154         369         68.00           67.00         06700 OCUPATI ONAL THERAPY         0.317742         1, 154         369         68.00           69.00         06800 SPEECH PATHOLOGY         0.216175         3, 719         804         67.00           00         07000 ELECTROCARDI OLOGY         0.216175         3, 719				To Charges	Program	Program Costs	
INPATI ENT ROUTI NE SERVICE COST CENTERS           0.00         03000 ADULTS & PEDIATRICS         30.00           31.00         03100 INTENSIVE CARE UNIT         31.967         31.00           41.00         04100 SUBPROVIDER - IRF         0         41.00         41.00           ANCILLARY SERVICE COST CENTERS         0         0         43.00           ANCILLARY SERVICE COST CENTERS         0         0.220964         148,731         32.864         50.00           05300         05000 (DERATING ROM         0.220964         148,731         32.864         50.00           53.00         05300 ANESTHESI OLOGY         0.189878         110.111         20.966         53.00           54.00         05400 RADIOLOGY-DIAGNOSTIC         0.189878         10.111         20.966         60.00           65.00         06500 RESPI RATORY         0.336191         33.458         11.248         65.00           66.00         06600 PHYSI CAL THERAPY         0.216175         3,719         804         67.00           69.00         06600 OELECROCARDI OLOGY         0.216175         3,719         804         68.00           69.00         06600 DELECTROCARDI OLOGY         0.209131         14,717         3,078         69.00 <td< td=""><td></td><td></td><td></td><td></td><td>Charges</td><td></td><td></td></td<>					Charges		
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         03000 ADULTS & PEDIATRICS         274,633         30.00           41.00         41.00         41.00         41.00         41.00         41.00           43.00         005000 INTENSIVE CARE UNIT         31.967         31.00           ANCILLARY SERVICE COST CENTERS         70,190         41.00           ANCILLARY SERVICE COST CENTERS         0.43806         21,923         960         53.00           50.00         05000 [DERATING ROOM         0.220964         148,731         32,864         50.00           53.00         05300 ANESTHESI OLOGY         0.189878         110,111         20,908         63.00           54.00         06500 [RESPI RATORY THERAPY         0.336191         33,458         11,248         65.00           65.00         06500 [RESPI RATORY THERAPY         0.319742         1,154         369         68.00           66.00         06600 PHYSI CAL THERAPY         0.319742         1,154         369         68.00           67.00         06070 INDULT ONAL THERAPY         0.34874         0         77.05         69.00           70.00         07300 INFLORCHALOGRAPHY         0.54148         1,472         801         70.00           71.0							
30.00       03000       ADULTS & PEDIATRICS       274, 633       30.00         31.00       03100       INTENSIVE CARE UNIT       31,967       31.00         41.00       O4100       SUBPROVIDER - IRF       0       41.00         ANCIULTS & PEDIATRICS       70,190       43.00         43.00       O4300 NURSERY       70,190       43.00         ANCIULTARY SERVICE COST CENTERS       0.220964       148,731       32,864       50.00         50.00       055000       OPERATING ROOM       0.220964       148,731       32,864       50.00         54.00       05400 RADI OLOGY-DI AGNOSTIC       0.158988       48,913       7,777       54.00         65.00       06500       DESDRIATORY       0.336191       33,458       11,248       65.00         65.00       06500       OSTOCALT HERAPY       0.310742       1,154       369       66.00         67.00       06600       PHSI CALT HERAPY       0.216175       3,719       804       67.00         70.00       07000       ELECTROCARDI OLOGY       0.216175       3,719       804       67.00         70.00       07000       ELECTROCARDI OLOGY       0.216175       3,719       804       67.00				1.00	2.00	3.00	
31.00       03100       INTENSIVE CARE UNIT       31,967       31.00         41.00       04100       SUBPROVIDER - IRF       0       0         43.00       40100       SUBPROVIDER - IRF       0       0         ANCILLARY SERVICE COST CENTERS       0.220964       148,731       32,864       50.00         50.00       05000       APENTHESIOLOGY       0.043806       21,923       960       53.00         54.00       05400       RADIOLOGY-DIAGNOSTIC       0.189878       110,111       20,998       66.00         65.00       05600       RSPI RATORY THERAPY       0.336191       33.458       11.248       65.00         66.00       06600       PHYSI CAL THERAPY       0.319742       1,154       369       66.00         67.00       06700       0CUPATIONAL THERAPY       0.216175       3,119       804       67.00         69.00       06600       PHECH PATHOLOGY       0.216175       3,1459       66.00       69.00         69.00       06000       ELECTROCARDIOLOGY       0.319742       1,154       369       68.00         69.00       00000       ELECTROCARDED TO PATIENT       0.439113       51,865       22,775       11.00         70.000<							
41.00       04100       SUBPROVI DER - I RF       0       41.00         43.00       04300       NURSERY       70,190       43.00         AMOULLARY SERVI CE COST CENTERS       0.220964       148,731       32,864       50.00         53.00       05300       OPERATI NG ROOM       0.043806       21,923       960       53.00         54.00       05400       RADI LOGY - JI AGNOSTI C       0.158988       48,913       7,777       54.00         66.00       06000       LABORATORY       0.336191       33,458       11,248       65.00         65.00       06500       RESPI RATORY THERAPY       0.36191       33,458       11,248       65.00         66.00       06000       DCUPATI ONAL THERAPY       0.216175       3,719       804       67.00         67.00       06700       0C000 CUPATI ONAL THERAPY       0.29131       14,717       30.78       69.00         68.00       0SPECH PATHOLOGY       0.29131       14,717       30.78       69.00       0       72.00       70.00       71.00       72.00       70.00       70.00       07000       RELCTROCARDI OLOGY       0.380874       0       72.00       72.00       73.00       73.00       73.00       73.00							
43.00       04300       NURSERY       70, 190       43.00         ANCILLARY SERVICE COST CENTERS       0000       DEPRATI NG ROOM       0.220964       148, 731       32, 864       50.00         53.00       05300       ANESTHESI OLOGY       0.043806       21, 923       960       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.158988       48, 913       7,777       54.00         06.00       LABORATORY       0.189878       110, 111       20,098       60.00       65.00       0.6600       HABORATORY       0.336191       33,458       11,248       65.00       66.00       0.6600       PHYSI CAL THERAPY       0.216175       3,719       804       67.00       67.00       0.201471 ONAL THERAPY       0.216175       3,719       804       67.00       67.00       0.6000       LABORADIOLOGY       0.216175       3,719       804       67.00       67.00       60.00       65.00       0.6000       LECTROCARDI OLOGY       0.216175       3,719       804       67.00       67.00       67.00       67.00       CEURCECHALOGAR       0.019742       1,154       366       68.00       67.00       69.00       67.00       69.00       70.00       ELECTROCARDI OLOGY       0.544184       1,4772 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
ANCILLARY SERVICE COST CENTERS           50. 00         05000         OPERATING ROM         0.220964         148, 731         32, 864         50. 00           53. 00         05300         ANESTHESI OLOGY         0.043806         21, 923         960         53. 00           54. 00         05400         RABIOLOGY         0.043806         21, 923         960         53. 00           60. 00         06000         LABORATORY         0.158978         48, 913         7, 777         54. 00           60. 00         06000         LABORATORY         0.336191         33, 458         11, 248         65. 00           65. 00         06500         RESPI RATORY THERAPY         0.407166         3, 583         1, 459         66. 00           67. 00         06700         OCCUPATI ONAL THERAPY         0.216175         3, 719         804         67. 00           68. 00         68000         SPEECH PATHOLOGY         0.319742         1, 154         369         68. 00           70. 00         O7000         ELECTROCARDI OLOGY         0.209131         14, 717         3, 078         69. 00           70. 00         O7300         DRUGS CHARGED TO PATI ENTS         0.3427162         79, 459         33, 990         73. 00					-		
50.00       05000       OPERATI NG ROOM       0.220964       148, 731       32, 864       50.00         53.00       05300       ANESTHESI OLOGY       0.043806       21, 923       960       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.158988       48, 913       7, 777       54.00         60.00       LABORATORY       0.189878       110, 111       20, 908       60.00         65.00       06500       RESPI RATORY THERAPY       0.336191       33, 458       11, 248       65.00         66.00       06600       PHYSI CAL THERAPY       0.216175       3, 719       804       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.216175       3, 719       804       66.00         68.00       06800       SPECH PATHOLOGY       0.319742       1, 154       369       68.00         69.00       ELECTROENCEPHALOGRAPHY       0.544184       1, 472       801       70.00         70.00       OT200       ILECTROENCEPHALOGRAPHY       0.439113       51, 865       22, 775       71.00         73.00       O7300       DRUGS CHARGED TO PATIENTS       0.380874       0       0       72.00         73.00       O3000       <					70, 190		43.00
53.00       05300       ANESTHESI OLOGY       0.043806       21,923       960       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.158988       48,913       7,777       54.00         60.00       LABORATORY       0.158978       110,111       20,908       60.00         65.00       06500       RESPI RATORY THERAPY       0.336191       33,458       11,248       65.00         66.00       06600       PHYSI CAL THERAPY       0.407166       3,583       1,459       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.216175       3,719       804       67.00         68.00       06800       SPEECH PATHOLOGY       0.209131       14,717       3,078       69.00         70.00       07000       ELECTROCARDI OLOGY       0.209131       14,717       3,078       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.439113       51,865       22,775       71.00         73.00       O7200       IMPL.       DEV. CHARGED TO PATI ENTS       0.427762       79,459       33,990       73.00         74.00       07300       DRUGS CHARGED TO PATI ENTS       0.325636       0       0       76.00						00.0(1	
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.158988       49,913       7,777       54.00         60.00       06000       LABORATORY       0.189878       110,111       20,908       60.00         65.00       06500       RESPI RATORY THERAPY       0.336191       33,458       11,248       65.00         66.00       06400       PHYSI CAL THERAPY       0.407166       3,583       1,459       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.216175       3,717       804       67.00         68.00       06800       SPEECH PATHOLOGY       0.319742       1,154       369       68.00         69.00       06900       ELECTROCARDI OLOGA       0.206113       14,717       3,078       69.00         70.00       OT000       ELECTROCARDECEPHALOGRAPHY       0.544184       1,472       801       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.380874       0       0       76.97         76.97       CARDI AC REHABI LI TATI ON       0.538690       0       0       76.97         70.497							
60.00       06000       LABORATORY       0.189878       110, 111       20, 908       60.00         65.00       06500       RESPI RATORY THERAPY       0.336191       33, 458       11, 248       65.00         66.00       06600       PHYSI CAL THERAPY       0.216175       3, 719       804       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0.216175       3, 719       804       67.00         68.00       06800       SPEECH PATHOLOGY       0.319742       1, 154       369       68.00         69.00       06900       ELECTROCARDI OLOGY       0.209131       14, 717       3, 078       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.544184       1, 472       801       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.32528       0       0       76.00         76.97       CARDI AC REHABI LI TATI ON       0.538690       0       0       76.00         70.90       <							
65.00       06500       RESPIRATORY THERAPY       0.336191       33,458       11,248       65.00         66.00       06600       PHYSI CAL THERAPY       0.407166       3,583       1,459       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.216175       3,719       804       67.00         68.00       06800       SPEECH PATHOLOGY       0.319742       1,154       369       68.00         69.00       06900       ELECTROCARDI OLOGY       0.209131       14,717       3,078       89.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.544184       1,472       801       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.380874       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.3280874       0       73.00         76.00       03020       ONCOLOGY       0.753228       0       0       76.97         76.97       OR697       CARDI AC REHABI LI TATI ON       0.538690       0       0       76.97         90.00       09000       CLI NIC       0.325636       0       0       90.00       90.00         91.00       092000       OBSER							
66.00       06600       PHYSI CAL THERAPY       0.407166       3,583       1,459       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.216175       3,719       804       67.00         68.00       06800       SPEECH PATHOLOGY       0.319742       1,154       369       68.00         69.00       06900       ELECTROCARDI OLOGY       0.209131       14,717       3,078       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.544184       1,472       801       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.427762       79,459       33,990       73.00         76.00       03020       ONCOLOGY       0.753228       0       0       76.00         76.97       OT697       CARDI AC REHABI LI TATI ON       0.325636       0       0       90.00         09100       ELISERNCY       0.322032       ORCHORY       92.00       90.00       90.00       90.00       90.00       90.00       92.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
67.00       06700       0CCUPATIONAL THERAPY       0.216175       3,719       804       67.00         68.00       06800       SPEECH PATHOLOGY       0.319742       1,154       369       68.00         69.00       06900       ELECTROCARDIOLOGY       0.209131       14,717       3,078       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.544184       1,472       801       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.439113       51,865       22,775       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.427762       79,459       33,990       73.00         76.00       03020       ONCOLOGY       0.753228       0       0       76.00         76.97       OT697       CARDI AC REHABILITATION       0.538690       0       0       76.97         0000       09100       EMERGENCY       0.325636       0       0       90.00         91.00       09200       OBSERVATION BEDS (NON-DI STINCT PART       0.677501       0       0       92.00							
68.00       06800       SPEECH PATHOLOGY       0.319742       1,154       369       68.00         69.00       06900       ELECTROCARDI OLOGY       0.209131       14,717       3,078       69.00         70.00       07000       ELECTROCKRDEPHALOGRAPHY       0.544184       1,472       801       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.439113       51,865       22,775       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.427762       79,459       33,990       73.00         76.00       03020       ONCOLOGY       0.753228       0       0       76.00         76.97       07697       CARDI AC REHABI LI TATI ON       0.538690       0       0       76.97         000       09000       CLI NI C       0.325636       0       0       90.00         91.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.677501       0       0       92.00         920.00       09200       DBSERVATI ON BEDS (NON-DI STI NCT PART       0.677501       0       0       92.00							
69.00       06900       ELECTROCARDI OLOGY       0.209131       14,717       3,078       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.544184       1,472       801       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.439113       51,865       22,775       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.427762       79,459       33,990       73.00         76.00       03020       ONCOLOGY       0.753228       0       0       0       76.00         76.97       07697       CARDI AC REHABI LI TATI ON       0.538690       0       0       76.97         0000       09000       CLI NI C       0.3226366       0       0       90.00         91.00       09100       EMERGENCY       0.220432       36,079       7,953       91.00         92.00       09200       DSERVATI ON BEDS (NON-DI STI NCT PART       0.677501       0       0       92.00         200.00       Less PBP Cli nic Laboratory Services-Program only charges (line 61)       0       201.00       201.00							
70.00         07000         ELECTROENCEPHALOGRAPHY         0.544184         1,472         801         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENT         0.439113         51,865         22,775         71.00           72.00         07200         IMPL.         DEV. CHARGED TO PATIENTS         0.380874         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.427762         79,459         33,990         73.00           76.00         03020         ONCOLOGY         0.753228         0         0         76.00           76.97         OZARDI AC REHABILITATION         0.538690         0         0         76.97           0017911 ENT SERVICE COST CENTERS         0.325636         0         0         76.97           90.00         09000         CLINIC         0.325636         0         0         90.00           91.00         09100         EMERGENCY         0.220432         36,079         7,953         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0.677501         0         0         92.00           200.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.439113       51,865       22,775       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.427762       79,459       33,990       73.00         76.00       03020       ONCOLOGY       0.753228       0       0       76.00         76.97       ORADIA C REHABILITATION       0.538690       0       0       76.00         001704TI ENT SERVICE COST CENTERS       0.325636       0       0       0         90.00       09100       EMERGENCY       0.220432       36,079       7,953       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0.677501       0       0       92.00         200.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00       201.00							
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.380874       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.427762       79,459       33,990       73.00         76.00       03020       ONCOLOGY       0.753228       0       0       76.00         76.97       07697       CARDI AC       REHABILITATION       0.538690       0       0       76.97         001PATIENT SERVICE COST CENTERS       0.325636       0       0       90.00       900.00       91.00       90200       0BSERVATION BEDS (NON-DI STINCT PART       0.677501       0       92.00       9200       09200       0BSERVATION BEDS (NON-DI STINCT PART       0.677501       0       92.00       920.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00<							
73.00       07300       DRUGS CHARGED TO PATIENTS       0.427762       79,459       33,990       73.00         76.00       03020       ONCOLOGY       0.753228       0       0       76.00         76.97       07697       CARDI AC REHABILITATION       0.538690       0       0       76.97         0UTPATIENT SERVICE COST CENTERS       0.32263690       0       0       76.97         90.00       09100       EMERGENCY       0.325636       0       0       90.00         91.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0.677501       0       0       92.00         200.00       Utal (sum of lines 50 through 94 and 96 through 98)       555, 184       144,986       200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00							
76.00         03020         ONCOLOGY         0.753228         0         0         76.00           76.97         07697         CARDI AC_REHABILITATION         0.538690         0         0         76.97           OUTPATIENT SERVICE COST CENTERS         0         0.322636         0         0         90.00           90.00         09100         EMERGENCY         0.325636         0         90.00         91.00         92.00         085ERVATION BEDS (NON-DISTINCT PART         0.677501         0         0         92.00         0         92.00         0.677501         0         0         92.00         0         201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00         201.00							
76.97         07697         CARDI AC REHABILITATION         0.538690         0         76.97           OUTPATI ENT SERVICE COST CENTERS         0.0325636         0         0         90.00         91.00         90.00         CLINIC         0.325636         0         90.00         90.00         91.00         90.00         0.220432         36,079         7,953         91.00         92.00         09500         0.677501         0         0         92.00         92.00         0555,184         144,986         200.00         201.00         201.00         555,184         144,986         200.00         201.00         201.00         0         0         201.00         0         0         201.00         0         0         201.00         0         201.00         0         201.00         0         201.00         201.00         0         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         2							
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         0.325636         0         0         90.00           91.00         09100         EMERGENCY         0.220432         36,079         7,953         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0.677501         0         0         92.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         555,184         144,986         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00							
90.00         09000         CLINIC         0.325636         0         0         90.00           91.00         09100         EMERGENCY         0.220432         36,079         7,953         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.677501         0         0         92.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         555,184         144,986         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00				0. 5386	90 0	0	76.97
91.00         09100         EMERGENCY         0.220432         36,079         7,953         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0.677501         0         0         92.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         555,184         144,986         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00							
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0.677501         0         92.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         555,184         144,986         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00         201.00							
200.00         Total (sum of lines 50 through 94 and 96 through 98)         555, 184         144, 986         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00						7, 953	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				0. 6775	-	-	
					555, 184	144, 986	
202.00 Net charges (line 200 minus line 201) 555, 184 202.00		m only charges	(line 61)		0		
	202.00  Net charges (line 200 minus line 201)				555, 184		202.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0001	Peri od:	Worksheet D-3	
			001 45 7004	From 01/01/2015		
		Component (	CCN: 15-T001	To 12/31/2015	Date/Time Pre 1/16/2018 2:5	
		Titl	e XIX	Subprovider -	Cost	<u>z piii</u>
				IRF		
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	-	1	
30. 00 03000 ADULTS & PEDIATRICS				0		30.00
31. 00 03100 I NTENSI VE CARE UNI T				11.000		31.00
41.00 04100 SUBPROVI DER - I RF				11, 298		41.00
43. 00 04300 NURSERY				(		43.00
ANCI LLARY SERVI CE COST CENTERS			0.000	(4)		50.00
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI 0LOGY			0. 2209		-	50.00 53.00
					-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0.1589		-	54.00
60. 00 06000 LABORATORY			0. 1898			60.00 65.00
65. 00 06500 RESPIRATORY THERAPY			0.3361			
66. 00 06600 PHYSI CAL THERAPY			0.4071			
67.00 06700 OCCUPATIONAL THERAPY			0. 2161			
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY			0. 3197 0. 2091			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 5441			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 4391		-	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 3808			
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 3808			
76. 00 03020 0NC0L0GY			0. 7532			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 5386		-	76.97
OUTPATIENT SERVICE COST CENTERS			0. 5500	70	ή 0	/0. //
90. 00 09000 CLINIC			0. 3256	36 (	0	90.00
91. 00 09100 EMERGENCY			0. 2204		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 6775		0	
200.00 Total (sum of lines 50 through 94 and 96	6 through 98)		0.0773	12, 447	-	200.00
201.00 Less PBP Clinic Laboratory Services-Proc		(line 61)		12,447	3, 747	200.00
202.00 Net charges (line 200 minus line 201)	gram only charges			12, 447	,	202.00
			1	,,	I	1_02.00

1.00 1.01	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments	Title XVIII			pared:
1.00 1.01			Hospi tal	1/16/2018 2:53 PPS	
1.00 1.01				1.00	
1.01	DPG Amounts Other than Outlier Payments			1.00	
1.02	DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1 (	(see	0 3, 845, 823	
	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	1, 139, 261	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	or discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or di scharges occurri ng	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			16, 582 0	1
2.02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	•
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	1, 581, 902 83. 55	
- 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	noniad anding an	0.00	
5.00	or before 12/31/1996. (see instructions)	1 5		0. 00 0. 00	
5.00 7.00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified			0.00	
7.01	ACA Section 5503 reduction amount to the IME cap as specified If the cost report straddles July 1, 2011 then see instructio	under 42 CFR §412.105(1		0.00	
3. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	thic and osteopathic pro		0.00	8.00
3. 01	The amount of increase if the hospital was awarded FTE cap slithe cost report straddles July 1, 2011, see instructions.	ots under section 5503 d	of the ACA. If	0.00	8. 01
3. 02	The amount of increase if the hospital was awarded FTE cap slunder section 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02)	see	0.00	9.00
	FTE count for allopathic and osteopathic programs in the curr	ent year from your recor	rds		10.00
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00	11.00 12.00
	Total allowable FTE count for the prior year.				13.00
14.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,	0.00	14.00
	Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo	curo			16.00 17.00
	Adjusted rolling average FTE count	Sule			18.00
	Current year resident to bed ratio (line 18 divided by line 4	).		0.00000	19.00
	Prior year resident to bed ratio (see instructions)			0.00000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0 0	•
	Indirect Medical Education Adjustment for the Add-on for Secti Number of additional allopathic and osteopathic IME FTE resid		Sec. 412 105		23.00
	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)		,	0.00	
	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	
	IME payments adjustment factor. (see instructions)			0.00000	
	IME add-on adjustment amount (see instructions)	、 、		0	•
	IME add-on adjustment amount - Managed Care (see instructions	)		0	•
29. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	1)		0	
	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	4. 11	30.00
	Percentage of Medicaid patient days (see instructions)				31.00
	Sum of lines 30 and 31				32.00
	Allowable disproportionate share percentage (see instructions Disproportionate share adjustment (see instructions)	)		8. 82 109, 922	33.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period:	Worksheet E	
			From 01/01/2015 To 12/31/2015	Date/Time Pre	
		Title XVIII	Hospi tal	1/16/2018 2:53 PPS	oz pili
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		1		
5.00	Total uncompensated care amount (see instructions)		7, 647, 644, 885		
5.01	Factor 3 (see instructions)	tor zoro on this line) (soo	0. 000045389		
5. UZ	Hospital uncompensated care payment (If line 34 is zero, en instructions)		347, 119	300, 126	35.0
5.03	Pro rata share of the hospital uncompensated care payment a	mount (see instructions)	259, 626	75, 441	35.0
6.00	Total uncompensated care (sum of columns 1 and 2 on line 35		335, 067		36. (
	Additional payment for high percentage of ESRD beneficiary				
0. 00	Total Medicare discharges on Worksheet S-3, Part I excludin	g discharges for MS-DRGs	0		40.0
1 00	652, 682, 683, 684 and 685 (see instructions)	492 494 ap 495 (coo	0		111
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	663, 664 all 665. (See	0		41.0
1. 01	Total ESRD Medicare covered and paid discharges excluding M	IS-DRGs 652, 682, 683, 684	0		41. (
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42.
3.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,	682, 683, 684 an 685. (see	0		43.
4.00	instructions) Ratio of average length of stay to one week (line 43 divide	d by Line 11 divided by 7	0.000000		44.
4.00	days)	a by The 41 divided by 7	0.000000		44.
5.00	Average weekly cost for dialysis treatments (see instructio	ins)	0.00		45.
6.00	Total additional payment (line 45 times line 44 times line		0		46.
7.00	Subtotal (see instructions)		5, 446, 655		47.
8.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48.
	only. (see instructions)			Amount	
				Amount 1.00	
9.00	Total payment for inpatient operating costs (see instructio	ins)		5, 446, 655	49.
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I			400, 258	
1. 00	Exception payment for inpatient program capital (Wkst. L, P	t. III, see instructions)		0	51.
2.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	
3.00	Nursing and Allied Health Managed Care payment			0	
4.00 4.01	Special add-on payments for new technologies Islet isolation add-on payment			0	54. 54.
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	
6.00	Cost of physicians' services in a teaching hospital (see in			0	
7.00	Routine service other pass through costs (from Wkst. D, Pt.		rough 35).	0	57.
8.00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		0	
9.00	Total (sum of amounts on lines 49 through 58)			5, 846, 913	
0.00	Primary payer payments	wa line (0)		4, 481	
1.00 2.00	Total amount payable for program beneficiaries (line 59 min Deductibles billed to program beneficiaries	lus Tine 60)		5, 842, 432 665, 880	
3.00	Coinsurance billed to program beneficiaries			1, 260	
4.00	Allowable bad debts (see instructions)			109, 657	
5.00	Adjusted reimbursable bad debts (see instructions)			71, 277	65
5.00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		18, 039	66
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			5, 246, 569	
8.00	Credits received from manufacturers for replaced devices fo			0	
9.00 0.00	Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER AD HISTMENTS (SEE INSTRUCTIONS) (SPECIEV)	O. (FOR SUB SEE INSTRUCTIONS	)	0	
0.00 0.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT			0	
0.88	SCH or MDH volume decrease adjustment			0	
	Pioneer ACO demonstration payment adjustment amount (see in	structions)		0	
	HSP bonus payment HVBP adjustment amount (see instructions)			0	
0. 89	USD bonus powert UDD adjustment amount (see instructions)			0	
0. 89 0. 90 0. 91	HSP bonus payment HRR adjustment amount (see instructions)				
0. 89 0. 90 0. 91 0. 92	Bundled Model 1 discount amount (see instructions)			0	
0. 89 0. 90 0. 91				0 -9, 135 -7, 520	70.

CALCULATION OF RELIBURSEMENT SETTLEMENT       Provider CCN: 15-0001       Period: To 12/37/2015       Worksheet E Part A         To 200       Title XVIII       Hospital       PPS         To 2010       FFX (yyyy)       Amount       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<	Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
FFY (yyyy)         Amount           0         1.00           70.96         Low volume adjustment for federal fiscal year for the period prior to 10/1)         0         1.00           70.97         Low volume adjustment for federal fiscal year for the period prior to 10/1)         0         0         70.96           70.97         Low volume adjustment for federal fiscal year for the period ending on or after 10/1)         0         0         70.96           70.98         Low Volume Payment.3         0         70.97         0         70.97           70.98         Low Volume Payment.3         0         70.98         0         70.99           71.01         Sequestratio nadjustment (see instructions)         0         70.98         0         70.98           71.01         Sequestratio nadjustment (see instructions)         0         70.98         0         70.98           71.01         Sequestration adjustment for contractor use only)         5,112,471         72.00         71.01         72.07           72.00         Tentative settlement (for contractor use only)         5,112,471         72.07         73.00         75.00           75.00         Depresting outlier amount from Wsst. L, Pt. A, line 2         0         0         0         0         0         0         <	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT				From 01/01/2015 To 12/31/2015	Part A Date/Time Prep	
01.0070.96Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)0070.9670.97Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)0070.9670.98Low Volume Payment-3070.9870.9970.9970.99HAC adjustment amount (see instructions)0070.9971.00Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)5, 229,91471.0071.01Sequestration adjustment (for contractor use only)5, 112,47172.0072.00Interim payments5, 112,47172.0073.00Tentested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2090.0070.00Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)090.0091.00Operating outlier reconciliation adjustment amount (see instructions)091.0092.00Operating outlier reconciliation adjustment amount (see instructions)092.0093.00Capital outlier reconciliation adjustment amount (see instructions)093.0094.00Har ause of money for capital related expenses (see instructions)096.0095.00Time value of money for capital related expenses (see instructions)0096.00Time value of money for capital related expenses (see instructions)0096.00Time valu				Title	XVIII	Hospi tal	PPS	
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)       0       0       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)       0       0       70.97         70.98       Low Volume Payment-3       0       70.98       0       70.98         70.98       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)       0       0       70.98         70.98       Low Volume Payment-3       0       70.98       0       70.99         71.00       Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)       5,229,914       71.00       70.47         72.00       Interim payments       5,112,471       71.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       74.00       73.00       73.00       74.00       73.00       73.00       73.00       74.00       74.00       74.00       74.00 <td< td=""><td></td><td></td><td></td><td></td><td>FFY</td><td>(уууу)</td><td>Amount</td><td></td></td<>					FFY	(уууу)	Amount	
the corresponding federal year for the period prior to 10/1)         0         70.97           Low volume adjustment for federal yisar for the period ending on or after 10/1)         0         0         70.97           Low Volume Adjustment amount (see instructions)         0         0         70.97           0.99         HAC adjustment amount (see instructions)         0         70.99           71.00         Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)         5,229,914         71.00           72.00         Interim payments         0         73.00         104,598         71.20           73.00         Tentative settlement (for contractor use only)         5,112,471         72.94         73.00           76.00         Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2         0         73.00         73.00           70.00         Operating outlier from Wkst. E, Pt. A, line 2 (see instructions)         0         90.00         90.00         92.00           70.0         Operating outlier reconciliation adjustment amount (see instructions)         0         91.00         92.00         93.00         91.00         92.00         93.00         93.00         94.00         96.00         95.00         95.00         95.00         95.00         95.00         96.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>1.00</td> <td></td>						0	1.00	
the corresponding Federal year for the period ending on or after 10/1)         0         70.98           1000000000000000000000000000000000000	70. 96			n column O		0	0	70. 96
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)       5, 229, 914       71.00         71.00       Interim payments       0       70.98       70.98         72.00       Interim payments       0       104, 598       71.01         73.00       Tentative settlement (for contractor use only)       0       73.00         74.00       Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)       12, 845       74.00         75.00       Potested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2       0       0       0         70.00       Operating outlier reconciliation adjustment amount (see instructions)       0       90.00       90.00       91.00         70.01       Capital outlier reconciliation adjustment amount (see instructions)       0       92.00       92.00       92.00       92.00       93.00       93.00       93.00       93.00       93.00       94.00       95.00       93.00       94.00       95.00       95.00       95.00       95.00       96.00       95.00       96.00       96.00       96.00       96.00       96	70. 97					0	0	70. 97
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)       5,229,914       71.00         71.01       Sequestration adjustment (see instructions)       104,598       5,112,471       72.00         72.00       Interim payments       0       73.00       73.00       73.00       73.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       75.00       92.00       99.00       91.00       92.00       99.00       91.00       92.00       99.00       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       95.00       95.00       95.00       95.00       94.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95.00       95	70. 98		5	,			0	70. 98
71.01       Sequestration adjustment (see instructions)       104,598       71.01         72.00       Interim payments       5,112,471       72.00         73.00       Tentative settlement (for contractor use only)       5,112,471       72.00         74.00       Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)       12,845       74.00         75.00       Protested amounts (nonallowable cost report items) in accordance with       63,301       75.00         70.85       Protested amounts (nonallowable cost report items) in accordance with       63,301       75.00         70.86       CMS Pub. 15.2, chapter 1, §115.2       7       63,301       75.00         70.00       Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)       0       90.00         91.00       Capital outlier reconciliation adjustment amount (see instructions)       0       92.00         92.00       Operating outlier reconciliation adjustment amount (see instructions)       0       93.00         93.00       Capital outlier for operating express (see instructions)       0       93.00         96.00       Time value of money for operating express (see instructions)       0       96.00         96.00       Time value of money for capital related expenses (see instructions)       0       0       96.00	70.99						0	70.99
71.01       Sequestration adjustment (see instructions)       104,598       71.01         72.00       Interim payments       5,112,471       72.00         73.00       Tentative settlement (for contractor use only)       5,112,471       72.00         74.00       Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)       12,845       74.00         75.00       Protested amounts (nonallowable cost report items) in accordance with       63,301       75.00         70.85       Protested amounts (nonallowable cost report items) in accordance with       63,301       75.00         70.86       CMS Pub. 15.2, chapter 1, §115.2       7       63,301       75.00         70.00       Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)       0       90.00         91.00       Capital outlier reconciliation adjustment amount (see instructions)       0       92.00         92.00       Operating outlier reconciliation adjustment amount (see instructions)       0       93.00         93.00       Capital outlier for operating express (see instructions)       0       93.00         96.00       Time value of money for operating express (see instructions)       0       96.00         96.00       Time value of money for capital related expenses (see instructions)       0       0       96.00	71.00	Amount due provider (line 67 minus lines 68	plus/minus lines (	59 & 70)			5, 229, 914	71.00
72.00       Interim payments       5, 112, 471       72.00         73.00       Tentative settlement (for contractor use only)       0       73.00         74.00       Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)       12, 845       74.00         75.00       Protested amounts (nonal lowable cost report items) in accordance with       63, 301       12, 845       75.00         70.00       Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)       0       90.00       90.00         90.00       Operating outlier reconciliation adjustment amount (see instructions)       0       91.00       92.00         92.00       Operating outlier reconciliation adjustment amount (see instructions)       0       92.00       92.00         94.00       The value of money for operating expenses (see instructions)       0       93.00       0.00       94.00         95.00       Time value of money for capital related expenses (see instructions)       0       95.00       96.00       96.00         96.00       Time value of money for capital related expenses (see instructions)       0       0       96.00         97.00       HSP Bonus Payment Amount       0       0       0       0       0         96.00       Time value of money for capital related expenses (see instructions)	71.01							
73.00       Tentative settlement (for contractor use only)       0       73.00         74.00       Bal ance due provider (Program) (line 71 minus lines 71.01, 72, and 73)       12,845       74.00         75.00       Protested amounts (nonal lowable cost report items) in accordance with       63,301       75.00         75.00       Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)       0       90.00         90.00       Operating outlier reconciliation adjustment amount (see instructions)       0       91.00         91.00       Capital outlier reconciliation adjustment amount (see instructions)       0       92.00         92.00       Operating outlier reconciliation adjustment amount (see instructions)       0       92.00         93.00       Capital outlier for operating expenses (see instructions)       0       93.00         96.00       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         96.00       HSP Bonus Payment Amount       0       0       0         100.00       HSP Bonus amount (see instructions)       0       0       0         96.00       HSP Adjustment factor (see instructions)       0       0       0	72.00							
74.00       Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)       12,845       74.00         75.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2       63,301       75.00         70.00       Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)       0       90.00       90.00         90.00       Operating outlier from Wkst. L, Pt. I, line 2       0       91.00       0       91.00         92.00       Operating outlier reconciliation adjustment amount (see instructions)       0       92.00       92.00       92.00       090.00       92.00       92.00       92.00       92.00       091.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       9	73.00		v)					
75.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)       63, 301       75.00         90.00       Operating outlier amount from Wkst. E, Pt. A, line 2 (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       94.00         95.00       Time value of money for operating expenses (see instructions)       0       0       95.00         95.00       Time value of money for capital related expenses (see instructions)       0       96.00       96.00         96.00       Time value of money for capital related expenses (see instructions)       0       0       0         91.00       0       0       0       0       0       0       0         92.00       HSP Bonus Payment Amount       0       0       0       0       0       0       0       0       0       0       0       0       0       0<	74.00			and 73)			12, 845	74.00
CMS Pub. 15-2, chapter 1, §115.2TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)90.00Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)091.00Capital outlier from Wkst. L, Pt. I, line 2092.00Operating outlier reconciliation adjustment amount (see instructions)093.00Capital outlier reconciliation adjustment amount (see instructions)094.00The rate used to calculate the time value of money (see instructions)095.00Time value of money for operating expenses (see instructions)096.00Time value of money for capital related expenses (see instructions)096.00Time value of money for capital related expenses (see instructions)096.00HSP Bonus Payment Amount00100.00HSP bonus amount (see instructions)0097.0000098.00HVBP adjustment for HSP Bonus Payment0099.0000.000000000.0000000099.00000090.00000090.00000091.00HKR Adjustment for HSP Bonus payment (see instructions)0092.00000093.0000095.0000095.0000095.0000095.0000095.00000<								
90.00 91.00 (2apital outlier from Wkst. L, Pt. I, line 2 (2apital outlier from Wkst. L, Pt. I, line 2 (2apital outlier reconciliation adjustment amount (see instructions) (93.00 (2apital outlier reconciliation adjustment amount (see instructions) (93.00 (2apital outlier reconciliation adjustment amount (see instructions) (94.00 (95.00 (96.00) (7) The rate used to calculate the time value of money (see instructions) (96.00) (7) Time value of money for operating expenses (see instructions) (96.00)0 (90.00 (92.00) (93.00) 		CMS Pub. 15-2, chapter 1, §115.2					,	
91.00Capital outlier from Wkst. L, Pt. I, line 2091.0092.00Operating outlier reconciliation adjustment amount (see instructions)092.0093.00Capital outlier reconciliation adjustment amount (see instructions)092.0094.00The rate used to calculate the time value of money (see instructions)093.0095.00Time value of money for operating expenses (see instructions)096.0096.00Time value of money for capital related expenses (see instructions)096.0096.00Time value of money for capital related expenses (see instructions)096.0097.00HSP Bonus Payment Amount000100.00HSP adjustment for HSP Bonus Payment000101.00HVBP adjustment for HSP bonus payment (see instructions)000102.00HVBP adjustment for HSP Bonus Payment000103.00HRR adjustment for (see instructions)000103.00HRR adjustment factor (see instructions)00.0000103.00					1		-	
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       93.00         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         96.00       Time value of money for capital related expenses (see instructions)       0       96.00         97.00       HSP Bonus Payment Amount       1.00       2.00         100.00       HSP bonus amount (see instructions)       0       0         101.00       HVBP adjustment for HSP Bonus Payment       0       0         101.00       HVBP adjustment for HSP bonus payment (see instructions)       0       0       102.00         HRR Adjustment for HSP Bonus Payment       0       0       0       102.00       102.00         HRR Adjustment for (see instructions)       0       0       0       0       102.00         103.00       HRR adjustment factor (see instructions)       0.0000       0.0000       103.00 <td></td> <td></td> <td>A, line 2 (see inst</td> <td>tructions)</td> <td></td> <td></td> <td>-</td> <td></td>			A, line 2 (see inst	tructions)			-	
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       95.00         96.00       Time value of money for capital related expenses (see instructions)       0       96.00         97.00       Time value of money for capital related expenses (see instructions)       0       96.00         97.00       Time value of money for capital related expenses (see instructions)       0       0       96.00         97.00       Time value of money for capital related expenses (see instructions)       0       0       96.00         97.00       Time value of money for capital related expenses (see instructions)       0       0       100.00         98.00       HSP Bonus Payment Amount       0       0       0       0       100.00         98.00       HVBP Adjustment for HSP Bonus Payment       0       0       0       0       101.00         99.00       HVBP Adjustment for HSP Bonus Payment       0       0       0       0       102.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>							0	
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         96.00       Time value of money for capital related expenses (see instructions)       0       96.00         96.00       HSP Bonus Payment Amount       1.00       2.00         HSP Bonus Payment Amount       0       0       0         100.00       HSP bonus amount (see instructions)       0       0       100.00         HVBP Adj ustment for HSP Bonus Payment       0       0       0       101.00       100.0000000       101.00         101.00       HVBP adj ustment for HSP bonus payment (see instructions)       0       0       0       102.00         HRR Adj ustment for HSP Bonus Payment       0       0       0       102.00       102.00         HRR Adj ustment factor (see instructions)       0       0       0       0       0         103.00       HRR adj ustment factor (see instructions)       0.00000       0.00000       103.00							0	
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       0n/After 10/1         Intervalue of money for capital related expenses (see instructions)         Prior to 10/1       0n/After 10/1         Intervalue of money for capital related expenses (see instructions)         Prior to 10/1       0n/After 10/1         Intervalue of money for capital related expenses (see instructions)         Intervalue of money for capital related expenses (see instructions)         Prior to 10/1       0n/After 10/1         Intervalue of money for capital related expenses (see instructions)         Intervalue of money for capital related expenses (see instructions)         Intervalue of money for capital related expenses (see instructions)         Intervalue of money for table bonus payment         Intervalue of money for capital related expenses (see instructions)         Intervalue of money for table bonus payment         Intervalue of money for table bonus payment (see instructions)         Intervalue of money for table bonus payment (see instructions)         Intervalue of money f							-	
96.00       Time value of money for capital related expenses (see instructions)       0       96.00         Prior to 10/1 0n/After 10/1         Intervalue of money for capital related expenses (see instructions)         Prior to 10/1 0n/After 10/1         1.00       2.00         HSP Bonus Payment Amount         100.00       HSP bonus amount (see instructions)       0       0       100.00         HVBP Adjustment for HSP Bonus Payment         101.00       HVBP adjustment factor (see instructions)       0       0       0       102.00         HRR Adjustment for HSP Bonus Payment         103.00       HRR adjustment factor (see instructions)       0       0       0       103.00				uctions)				
HSP Bonus Payment Amount       Pri or to 10/1       On/After 10/1         1.00       2.00         HSP bonus amount (see instructions)       0       0         HVBP Adjustment for HSP Bonus Payment       0       0         101.00       HVBP adjustment factor (see instructions)       0.00000000       0.000000000         102.00       HVBP adjustment for HSP bonus payment (see instructions)       0       0       0         102.00       HVBP adjustment for HSP bonus payment       0       0       0       102.00         HRR Adjustment for HSP Bonus Payment       0       0       0       102.00         HRR Adjustment for there instructions)       0       0       0       102.00         103.00       HRR adjustment factor (see instructions)       0.0000       0.0000       103.00		J 1 5 1	• • • • • • • • • • • • • • • • • • • •				-	
HSP Bonus Payment Amount     1.00     2.00       100.00     HSP bonus amount (see instructions)     0     0       HVBP Adj ustment for HSP Bonus Payment     0.000000000     100.00       101.00     HVBP adj ustment factor (see instructions)     0.000000000     0.000000000       102.00     HVBP adj ustment for HSP bonus payment (see instructions)     0     0     102.00       HRR Adj ustment for HSP Bonus Payment     0     0     0     102.00       HRR Adj ustment for HSP Bonus Payment     0     0     0     102.00	96.00	lime value of money for capital related expe	enses (see instruct	tions)			Ũ	96.00
HSP Bonus Payment Amount         100.00       HSP bonus amount (see instructions)       0       0       100.00         HVBP Adjustment for HSP Bonus Payment       0       0       0       100.00         101.00       HVBP adjustment factor (see instructions)       0.000000000       0.000000000       101.00         102.00       HVBP adjustment for HSP bonus payment (see instructions)       0       0       0       102.00         HRR Adjustment for HSP Bonus Payment       0       0       0       102.00       102.00         HRR Adjustment for HSP Bonus Payment       0       0       0       102.00       103.00								
100.00HSP bonus amount (see instructions)000100.00HVBP Adjustment for HSP Bonus Payment0.0000000000.000000000101.00101.00HVBP adjustment factor (see instructions)000102.00102.00HVBP adjustment for HSP Bonus Payment00102.00HRR Adjustment for HSP Bonus Payment00102.00103.00HRR adjustment factor (see instructions)0.00000.0000						1.00	2.00	
HVBP Adj ustment for HSP Bonus Payment         101.00       HVBP adj ustment factor (see instructions)       0.000000000       0.000000000         102.00       HVBP adj ustment amount for HSP bonus payment (see instructions)       0       0       102.00         HRR Adj ustment for HSP Bonus Payment       0       0       102.00       102.00         HRR Adj ustment for HSP Bonus Payment       0       0       103.00       0.0000       103.00	100.00							100.00
101.00HVBP adjustment factor (see instructions)0.0000000000.000000000102.00HVBP adjustment amount for HSP bonus payment (see instructions)00HRR Adjustment for HSP Bonus Payment00103.00HRR adjustment factor (see instructions)0.00000.0000	100.00					0	0	100.00
102.00HVBP adjustment amount for HSP bonus payment (see instructions)00102.00HRR Adjustment for HSP Bonus Payment103.00HRR adjustment factor (see instructions)0.0000103.00	101 00					0.0000000000	0.0000000000	101 00
HRR Adjustment for HSP Bonus Payment         103.00 HRR adjustment factor (see instructions)         0.0000 103.00			t (coo instruction	-)				
103.00         HRR adjustment factor (see instructions)         0.0000         0.0000         103.00	102.00		L (See Instructions	>)		0	0	102.00
	103.00					0.0000	0.0000	103.00
			(see instructions)	)				

	Financial Systems		JOHNSON MEMORI	Provider C	CN: 15-0001 P	eriod:	u of Form CMS-2 Worksheet E	
vC					F	rom 01/01/2015	Part A Exhibi	
						0 12/31/2015	Date/Time Pre 1/16/2018 2:53	pare 2 pm
			1 1		XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0			0	1
01	payments DRG amounts other than outlier payments for discharges	1.01	3, 845, 823	0	3, 845, 823		3, 845, 823	1
)2	occurring prior to October 1 DRG amounts other than outlier	1. 02	1, 139, 261	0		1, 139, 261	1, 139, 261	1
	payments for discharges occurring on or after October 1							
)3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1
4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1
0	Outlier payments for discharges (see instructions)	2.00	16, 582	0	,	5, 880	16, 582	
)1	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2
00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3
00	Managed care simulated payments	3.00	1, 581, 902	0	0	0	0	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part A, Line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 000000	0. 000000		Ę
0	IME payment adjustment (see instructions)	22.00	0	0	o	0	0	e
1	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	ė
	Indirect Medical Education Adju					1		
0	IME payment adjustment factor	27.00	0. 000000	0.000000	0. 000000	0. 000000		7
0	(see instructions) IME adjustment (see	28.00	о	0	0	0	0	8
1	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	0	0	0	8
0	instructions) Total IME payment (sum of	29.00	0	0	0	0	0	ç
1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	ç
	Disproportionate Share Adjustme	ent	<u> </u>					
00	Allowable disproportionate share percentage (see	33.00	0. 0882	0. 0882	0. 0882	0. 0882		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	109, 922	0	84, 801	25, 121	109, 922	1'
01	Uncompensated care payments Additional payment for high per	36.00 Contage of ESE	335,067	0 ti scharges	259, 626	75, 441	335, 067	11
00	Total ESRD additional payment	46.00		0 O	0	0	0	12
00	(see instructions) Subtotal (see instructions)	47.00	5, 446, 655	0	4, 200, 952	1, 245, 703	5, 446, 655	13
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0	0	0	0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	5, 446, 655	0	4, 200, 952	1, 245, 703	5, 446, 655	15
00	Payment for inpatient program capital	50.00	400, 258	0	308, 380	91, 878	400, 258	16
00	Special add-on payments for new technologies	54.00	0	0	o	0	0	
01 02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	0	0	o	О	0	17 17
00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	o	О	0	18

Health Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 1/16/2018 2:5	pared:
			Title	XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
19.00 SUBTOTAL			0	4, 509, 33	2 1, 337, 581	5, 846, 913	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	398, 975	0	307, 61	6 91, 359	398, 975	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	1, 283	0	76	4 519	1, 283	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	5.00	0. 0000	0,0000	0, 000	0.0000		22.00
percentage (see instructions)	0.00	0.0000	0.0000	0.000	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	0.000	0 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	400, 258	0	308, 38	0 91, 878	400, 258	26.00
	W/S E, Part A	(Amounts to E,					
	line	Part A)					
	0	1.00	2.00	3.00	4.00	5.00	
27.00 Low volume adjustment factor				0. 07660	7 0. 087679		27.00
28.00 Low volume adjustment (transfer amount to Wkst. E,	70. 96			345, 44	6	345, 446	28.00
Pt. A, line) 29.00 Low volume adjustment (transfer amount to Wkst. E,	70. 97				117, 278	117, 278	29.00
Pt. A, line) 100.00 Transfer low volume adjustments to Wkst. E, Pt. A.		Ν					100.00

IOSPI	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2015 To 12/31/2015	Date/Time Prep 1/16/2018 2:52	pared:
				XVIII	Hospi tal	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	
. 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	3, 845, 823	3, 845, 82		3, 845, 823	1.01
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1, 139, 261		1, 139, 261	1, 139, 261	1.02
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. 03
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
. 00	Outlier payments for discharges (see instructions)	2.00	16, 582	10, 70	5, 880	16, 582	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0		3.00
1.00	Managed care simulated payments	3.00	1, 581, 902		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 00000	0.00000		5.00
5.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
o. 01	IME payment adjustment for managed care (see instructions)	22.00	0		0 0		6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422 of t	he MMA			
. 00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0. 000000		7.00
3.00	IME adjustment (see instructions)	28.00	0		0 0	-	8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0		8.01
9.00 9.01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0		0 0	0	9.00 9.01
. 01	Disproportionate Share Adjustment	29.01	0		0 0	0	9.01
0. 00		33.00	0.0882	0. 088	0. 0882		10.00
1. 00	(see instructions) Disproportionate share adjustment (see	34.00	109, 922			109, 922	11.00
1. 01	instructions) Uncompensated care payments	36.00	335, 067	259, 62	26 75, 441	335, 067	11. 01
2.00	Additional payment for high percentage of ESR Total ESRD additional payment (see	D beneficiary 46.00	di scharges		0 0	0	12.00
	instructions)						
	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47.00 48.00	5, 446, 655 0	4, 200, 95	52 1, 245, 703 0 0		13.00 14.00
5.00	Total payment for inpatient operating costs (see instructions)	49.00	5, 446, 655	4, 200, 95	1, 245, 703	5, 446, 655	15.00
6.00	Payment for inpatient program capital	50.00	400, 258	308, 89	99 91, 359	400, 258	16.00
7.00	Special add-on payments for new technologies	54.00	0		0 0	0	17.00
7.01	Net organ acquisition cost						17.0 [°]
7. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
8. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.00
	SUBTOTAL		1	4, 509, 85	1, 337, 062	5, 846, 913	

	Financial Systems	JOHNSON MEMOR			In Lie	u of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2015 To 12/31/2015		pared:
			Title	XVIII	Hospi tal	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	398, 975	307, 6	16 91, 359	398, 975	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
21.00	Capital DRG outlier payments	2.00	1, 283	1, 2	33 0	1, 283	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	0.000	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	0.000	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	400, 258	308, 8	99 91, 359	400, 258	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	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	-9, 135	-5, 5	-3, 608	-9, 135	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	30. 01
	HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions)	70. 94 70. 91	-7, 520 0	-6, 1	53 -1, 367 0 0	-7, 520 0	
						(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.		N				100.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0001 Period: From 01/01/20 To 12/31/20		
	Title XVIII Hospital	PPS	1
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2, 514	
2.00 3.00	Medical and other services reimbursed under OPPS (see instructions) PPS payments	6, 987, 791 6, 018, 398	•
3.00 4.00	Outlier payment (see instructions)	54, 785	•
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00	Organ acqui si ti ons	0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)	2, 514	
	COMPUTATION OF LESSER OF COST OR CHARGES	•	]
10 00	Reasonable charges	( ( ( )	1 1 0 00
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	6, 469	12.00 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	6, 469	
	Customary charges		1
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17 00
	Total customary charges (see instructions)	6, 469	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	3, 955	
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	2, 514	21.00
22.00	Interns and residents (see instructions)	0	
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, 8 and 9)	6, 073, 183	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)	0	25.00
	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1, 306, 549	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	4, 769, 148	
	instructions)		
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)	0 4, 769, 148	
	Primary payer payments	2, 229	1
32.00	Subtotal (line 30 minus line 31)	4, 766, 919	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
	Composite rate ESRD (from Wkst. I-5, line 11)	0 250, 038	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	162, 525	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	138, 253	
37.00	Subtotal (see instructions)	4, 929, 444	37.00
	MSP-LCC reconciliation amount from PS&R	-44	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
39.50 39.98	Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replaced devices (see instructions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	1
40. 00	Subtotal (see instructions)	4, 929, 488	40.00
40. 01	Sequestration adjustment (see instructions)	98, 590	
41.00	Interim payments	4, 813, 392	
42.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)	0 17, 506	•
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	1
	<u>§115. 2</u>		]
	TO BE COMPLETED BY CONTRACTOR		00.07
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0	•
	The rate used to calculate the Time Value of Money		91.00
	Time Value of Money (see instructions)	0.00	
	Total (sum of lines 91 and 93)	0	94.00

	Financial Systems JOHNSON MEMORIAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	
		Title XVIII	Subprovi der – I RF	1/16/2018 2: 5 PPS	<u>2 pm</u>
		•	· · ·	1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			88	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	tions)		20	2.00
3.00	PPS payments			107	3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5	ctions)		0.000	5.00 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			00	11.00
	Reasonable charges			•	
12.00	Ancillary service charges				12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			205	14.00
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 fo		n a chargebasis	0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(	e)		0,00000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	117	
	instructions)	-			
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH se	e instructions)		88	21.00
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			107	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (fo	r CAH, see instructions)		0	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			195	27.00
20.00	instructions)	ing (0)			20.00
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)	ine 50)		0	28.00 29.00
30.00	Subtotal (sum of lines 27 through 29)			195	
31.00	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31)	250)		195	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC Composite rate ESRD (from Wkst. I-5, line 11)	JES)		0	33.00
34.00	Allowable bad debts (see instructions)			0	
35.00	Adjusted reimbursable bad debts (see instructions)			0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			195 0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
39.98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	tions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0	
40. 00 40. 01	Sequestration adjustment (see instructions)			4	40.00
41.00	Interim payments			191	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)	nco with CMS Dub 15 0	chaptor 1	0	
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter I,	0	44.00
	TO BE COMPLETED BY CONTRACTOR			l	1
90.00	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)				94.00
					•

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2015 To 12/31/2015		
		Title	XVIII	Hospi tal	PPS	•
		I npati en	t Part A	Par	rt 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, 967, 11	6	4, 752, 854	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		•			
3.01	ADJUSTMENTS TO PROVIDER	07/26/2016	145, 35	5 07/26/2016	60, 538	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
2 50	Provider to Program	1	[	0	0	3.50
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.52
3.52				0	0	3. 53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		145, 35	-	60, 538	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 112, 47	1	4, 813, 392	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50				0	0	5.5
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)			_		, .
6.01	SETTLEMENT TO PROVIDER		12, 84		17, 506	6.01
6.02	SETTLEMENT TO PROGRAM			0	0	6.02
7.00	Total Medicare program liability (see instructions)		5, 125, 31	6 Contractor	4,830,898 NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	
8.00	Name of Contractor					8.00

IALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0001 CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015		pared 2 pm
		Ti tl e	XVIII	Subprovider - IRF	PPS	
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
0.0	l <del>,</del> , , , , , , , , , , , , , , , , , ,	1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider 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		681, 4	0	191 0	1.0 2.0
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) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER	07/26/2016	5, 5	37	0	3. (
02				0	0	3. (
03				0	0	3.
04				0	0	3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		5, 5	37	0	3.
	3. 50-3. 98)		(07.0	o.F	101	
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)		687, 0	25	191	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.
	write "NONE" or enter a zero. (1) Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program					
50	TENTATIVE TO PROGRAM			0	0	5
51				0	0	5
52 99	Subtatal (sum of lines E 01 E 40 minus sum of line-			0	0	5 5
79	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			U	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
)1	SETTLEMENT TO PROVIDER			0	0	6
)2	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		687, 0		191	7
				Contractor Number	NPR Date (Mo/Day/Yr)	

Heal th	Financial Systems J0	HNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0001	Period:	Worksheet E-1	
				From 01/01/2015 To 12/31/2015		narod.
				10 12/31/2013	1/16/2018 2:53	
			Title XVIII	Hospi tal	PPS	
					1.00	
-	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD CO	OST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION A	ND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4	102 from Wkst.	S-3, Pt. I col. 15 line	14	1, 792	1.00
2.00	.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 .00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					3.00
4.00			-12		5, 637	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col.				172, 841, 803	5.00
6.00	Total hospital charity care charges from Wkst.				4, 169, 216	6.00
7.00	CAH only - The reasonable cost incurred for the	purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168					
8.00	Calculation of the HIT incentive payment (see in				348, 239	8.00
9.00	Sequestration adjustment amount (see instruction				6, 965	9.00
10.00	Calculation of the HIT incentive payment after		see instructions)		341, 274	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAN					
30.00	Initial/interim HIT payment adjustment (see ins	tructions)			362, 885	
31.00	Other Adjustment (specify)				0	31.00
32.00	Balance due provider (line 8 (or line 10) minus	line 30 and li	ne 31) (see instruction	s)	-21, 611	32.00

	Financial Systems JOHNSON MEMORIAL			u of Form CMS-2	2552-
ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2015	Worksheet E-3 Part III	
		Component CCN: 15-T001	To 12/31/2015	Date/Time Pre	oared
		•		1/16/2018 2:5	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			661, 950	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0322	2.
00	Inpatient Rehabilitation LIP Payments (see instructions)			40, 445	3.
. 00	Outlier Payments			9, 676	4.
. 00	Unweighted intern and resident FTE count in the most recent of	cost reporting period en	ding on or prior	0.00	5.
	to November 15, 2004 (see instructions)				
. 01	Cap increases for the unweighted intern and resident FTE cour	nt for residents that wer	e displaced by	0.00	5.
	program or hospital closure, that would not be counted without	it a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instructions)				_
. 00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	8.
	teaching program" (see instructions)			0.00	~
. 00	Intern and resident count for IRF PPS medical education adjus	stment (see instructions)		0.00	9.
0.00	Average Daily Census (see instructions)			3.263014	10.
1.00	Teaching Adjustment Factor (see instructions)			0. 000000	11.
2.00	Teaching Adjustment (see instructions)			710 071	12
3.00	Total PPS Payment (see instructions)			712, 071	13
4.00	Nursing and Allied Health Managed Care payments (see instruct	(i on)		0	14
5.00	Organ acquisition (DO NOT USE THIS LINE)	tructione)		0	15
6.00	Cost of physicians' services in a teaching hospital (see inst	(ructions)		0	
7.00	Subtotal (see instructions)			712, 071	17
8.00 9.00	Primary payer payments Subtotal (line 17 less line 18).			0 712 071	18. 19.
9.00 0.00	Deductibles			712, 071 6, 300	
1.00	Subtotal (line 19 minus line 20)			705, 771	20.
2.00	Coinsurance			4, 725	
3.00	Subtotal (line 21 minus line 22)			701, 046	
4.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		01,040	24
5.00	Adjusted reimbursable bad debts (see instructions)			0	25
5.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	26
7.00	Subtotal (sum of lines 23 and 25)			701, 046	27
3.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		01,010	28
9.00	Other pass through costs (see instructions)			0	29
0.00	Outlier payments reconciliation			0	30
1.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
1.50	Pioneer ACO demonstration payment adjustment (see instruction	าร)		0	31
1.99	Recovery of Accel erated Depreciation	-		0	31
2.00	Total amount payable to the provider (see instructions)			701, 046	
2. 01	Sequestration adjustment (see instructions)			14, 021	
	Interim payments			687, 025	
4.00	Tentative settlement (for contractor use only)			0	34.
5.00	Balance due provider/program (line 32 minus lines 32.01, 33,	and 34)		0	35.
6. 00	Protested amounts (nonallowable cost report items) in accorda	-	chapter 1,	0	36.
0. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4			9, 676	50.
	Outlier reconciliation adjustment amount (see instructions)			9, 878	50.
2.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)				53.

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Peri od:	Worksheet E-3	
			From 01/01/2015 To 12/31/2015	Part VII Date/Time Pre 1/16/2018 2:5	
		Title XIX	Hospi tal	Cost	2 pm
			Inpati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR X	I X SERVICES		
~~	COMPUTATION OF NET COST OF COVERED SERVICES		074.047		1
00	Inpatient hospital/SNF/NF services Medical and other services		374, 847	(50.047	1.0
00 00	Organ acquisition (certified transplant centers only)		0	650, 947	2.0 3.0
00 00	Subtotal (sum of lines 1, 2 and 3)		374, 847	650, 947	4.0
00	Inpatient primary payer payments		0	000, 717	5.0
00	Outpatient primary payer payments			0	6. C
00	Subtotal (line 4 less sum of lines 5 and 6)		374, 847	650, 947	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routine service charges		376, 790		8.0
00	Ancillary service charges		555, 184	2, 793, 084	9.0
. 00 . 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		10.0 11.0
. 00	Total reasonable charges (sum of lines 8 through 11)		931, 974	2, 793, 084	
. 00	CUSTOMARY CHARGES		751, 774	2, 793, 004	12.0
. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.0
	basi s	5			
. 00	Amounts that would have been realized from patients liable for	payment for services o	on O	0	14. (
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000	0.000000	
. 00	Total customary charges (see instructions)		931, 974	2, 793, 084	
. 00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	IT TThe 16 exceeds	557, 127	2, 142, 137	17.0
. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	ne O	0	18.0
. 00	16) (see instructions)			0	10. (
. 00	Interns and Residents (see instructions)		0	0	19. (
. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20. (
. 00	Cost of covered services (enter the lesser of line 4 or line 16		374, 847	650, 947	21. (
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	ompleted for PPS provi			
. 00	Other than outlier payments		0	0	
. 00 . 00	Outlier payments Program capital payments		0	0	23.
. 00	Capital exception payments (see instructions)		0		24.
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.
. 00	Titles V or XIX (sum of lines 21 and 27)		374, 847	650, 947	29.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Excess of reasonable cost (from line 18)		0	0	
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		374, 847	650, 947	
. 00	Deductibles		0	0	
. 00	Coinsurance Allowable bad debts (see instructions)		0	0	
. 00 . 00	Utilization review		0	0	34.
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	374, 847	650, 947	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0, 1, 347	0	37.
. 00	Subtotal (line 36 $\pm$ line 37)		374, 847	650, 947	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.
. 00	Total amount payable to the provider (sum of lines 38 and 39)		374, 847	650, 947	40.
	Interim payments		374, 847	650, 947	
. 00					1 40
. 00 . 00 . 00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordanc		0	0	

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001 Component CCN: 15-T001	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part VII Date/Time Pre	
		•		1/16/2018 2:5	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	_
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		45, 966		] 1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		45, 966	0	
00	Inpatient primary payer payments		0	_	5
00	Outpatient primary payer payments		15 0//	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		45, 966	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				4
0	Reasonable Charges		11 000		1,
00 00	Routine service charges Ancillary service charges		11, 298 12, 447	0	
00	Organ acquisition charges, net of revenue		12, 447	0	10
00	Incentive from target amount computation		0		11
00	Total reasonable charges (sum of lines 8 through 11)		23, 745	0	
00	CUSTOMARY CHARGES		20, 110		1
00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	1:
	basi s			-	
00	Amounts that would have been realized from patients liable for	n 0	0	14	
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	1
00	Total customary charges (see instructions)		23, 745	0	1
00	Excess of customary charges over reasonable cost (complete onl	ly if line 16 exceeds	0	0	1
	line 4) (see instructions)			_	
00	Excess of reasonable cost over customary charges (complete onl	ly if line 4 exceeds lin	e 22, 221	0	18
00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 7		23, 745	0	
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	- 2
00	Other than outlier payments		0	0	22
00	Outlier payments		0	0	
00	Program capital payments		0	-	2
00	Capital exception payments (see instructions)		0		2!
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	2
00	Customary charges (title V or XIX PPS covered services only)		0	0	28
00	Titles V or XIX (sum of lines 21 and 27)		23, 745	0	20
_	COMPUTATION OF REIMBURSEMENT SETTLEMENT				4
00	Excess of reasonable cost (from line 18)		22, 221	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	23, 745	0	
	Deductibles		0	0	
00	Coinsurance Allowable bad debts (see instructions)		0	0	
00 00	Utilization review		0	0	34
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	4 33)	23, 745	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 00)	23,745	0	
00	Subtotal (line 36 ± line 37)		23, 745	0	
00	Direct graduate medical education payments (from Wkst. E-4)		20, 740	0	3
00	Total amount payable to the provider (sum of lines 38 and 39)		23, 745	0	
00	Interim payments		23, 745	0	
00	Balance due provider/program (line 40 minus line 41)		0	0	
00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2,	0	0	
		nce with CMS Pub 15-2,			

	E SHEET (If you are nonproprietary and do not maintain	Provider C		eriod: rom 01/01/2015	Worksheet G	
ina-t il y)	ype accounting records, complete the General Fund column			o 12/31/2015	Date/Time Pre 1/16/2018 2:5	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	4, 834, 738	0	0	0	1 1.
00	Temporary investments	0	C		0	
00	Notes receivable	0	C	0	0	3
00	Accounts receivable	14, 999, 276		-	0	4
00	Other receivable	4, 860, 499		-	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	-2, 878, 642 1, 452, 912		U U	0	
00 00	Prepai d expenses	1, 354, 392	-	-	0	
00	Other current assets	24, 905, 525		0	0	
. 00	Due from other funds	0	0	0	0	10
. 00	Total current assets (sum of lines 1-10)	49, 528, 700		0	0	11
~~	FIXED ASSETS	4 742 220				1 10
. 00	Land Land improvements	4, 743, 329 1, 463, 185		-	0	12
00	Accumulated depreciation	-974, 092			0	
00	Bui I di ngs	58, 483, 192		-	0	15
. 00	Accumulated depreciation	-30, 220, 173		0	0	16
. 00	Leasehold improvements	0	C	-	0	17
. 00	Accumulated depreciation	0	0		0	18
. 00	Fixed equipment	12, 824, 093		, i i i i i i i i i i i i i i i i i i i	0	19
. 00	Accumulated depreciation Automobiles and trucks	-9, 682, 171		-	0	20
. 00	Accumulated depreciation	0		-	0	
	Major movable equipment	37, 840, 031		-	0	23
	Accumulated depreciation	-30, 628, 322		0	0	24
00	Minor equipment depreciable	0	( C	0	0	25
. 00	Accumulated depreciation	0	C	U U	0	26
. 00	HIT designated Assets	0	0		0	27
. 00	Accumulated depreciation Minor equipment-nondepreciable	8, 460, 938		-	0	28
. 00	Total fixed assets (sum of lines 12-29)	52, 310, 010			0	
. 00	OTHER ASSETS	02,010,010				
. 00	Investments	41, 055, 404	(	0	0	31
. 00	Deposits on Leases	0	C	-	0	32
. 00	Due from owners/officers	0	C	U U	0	33
. 00	Other assets	71, 375		-	0	34
. 00 . 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	41, 126, 779 142, 965, 489		-	0	35
. 00	CURRENT LIABILITIES	142, 905, 469		0	0	1 30
. 00	Accounts payable	1, 206, 767	0	0	0	37
. 00	Salaries, wages, and fees payable	0	( C	0	0	38
00	Payroll taxes payable	0	C	0	0	
	Notes and Loans payable (short term)	0	0	0	0	40
. 00	Deferred income	0	C	0	0	41
. 00	Accelerated payments Due to other funds	0	(	0	0	
. 00	Other current liabilities	3, 087, 969	-	-	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	4, 294, 736			0	
	LONG TERM LIABILITIES					
00	Mortgage payable	0	C		0	
. 00	Notes payable	0	0	-	0	47
00	Unsecured Loans	0		-	0	48
00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	0		-	0	50
00	Total liabilities (sum of lines 45 and 50)	4, 294, 736	-	-	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	138, 670, 753				52
00	Specific purpose fund		0			53
00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56 57
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	138, 670, 753	0	0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	142, 965, 489	0	0	0	60

Heal th	Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provider CC		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 1/16/2018 2:5	pared: 2 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
			0.00			5.00	
1.00	Fund balances at beginning of period	1.00	2.00 119,824,083	3.00	4.00	5.00	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	2.00         Net income (loss) (From Wkst. G-3, line 29)           3.00         Total (sum of line 1 and line 2)           4.00         TRANSFERS FROM OTHER FUNDS           5.00         6.00           6.00         7.00           8.00         9.00           10.00         Total additions (sum of line 4-9)           11.00         Subtotal (line 3 plus line 10)           12.00         Deductions (debit adjustments) (specify)           13.00         14.00           15.00         10.00	19, 248, 752 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-402, 082 119, 422, 001 19, 248, 752 138, 670, 753 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
19.00	sheet (line 11 minus line 18)		138, 670, 753		0		19.00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) TRANSFERS FROM OTHER FUNDS	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	Financial Systems JOHNSON MEMORIAL ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCN	I 15_0001	Period:	u of Form CMS-2 Worksheet G-2	
STATEN	ENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider CCM	1: 15-0001	From 01/01/2015 To 12/31/2015	Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services		10.005.5		10.005.504	
1.00			10, 295, 50	)4	10, 295, 504	1.00
2.00 3.00	SUBPROVIDER - IPF		1 472 0	(1	1 472 0/1	2.00 3.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER		1, 473, 80		1, 473, 861	4.00
4.00 5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	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)		11, 769, 30	65	11, 769, 365	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T		1, 910, 53	33	1, 910, 533	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				1 010 500	15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	1, 910, 53	33	1, 910, 533	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16)		13, 679, 89	20	12 (70 000	17.00
18.00	Ancillary services		29, 463, 39		13, 679, 898 132, 978, 930	
19.00	Outpatient services		27,403,3	0 25, 112, 850		
20.00	RURAL HEALTH CLINIC			0 23, 112, 030	23, 112, 030	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY			1, 656, 312	1, 656, 312	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER REVENUE			0 9, 510, 059		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	43, 143, 28	39 139, 794, 760	182, 938, 049	28.00
	G-3, Line 1) PART II - OPERATING EXPENSES					-
29.00	Operating expenses (per Wkst. A, column 3, line 200)			72, 975, 646		29.00
30.00	LOSS ON SALE OF ASSETS		392, 48			30.00
31.00			572, 40	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)			392, 485		36.00
37.00	FI SCAL SERVICES EXPENSES		1, 000, 00	00		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00	Total deductions (cum of lines 27 41)			0		41.00
42.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42	(transfor		1,000,000		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	) (transfer		72, 368, 131		43.00

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0001	Peri od: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prep 1/16/2018 2:5	pared:
				-	1.00	
1.00	Total patient revenues (from Wkst. G-2, Pa	art I, column 3, line	28)		182, 938, 049	1.00
2.00	Less contractual allowances and discounts	on patients' account	ts		112, 503, 604	2.00
3.00	Net patient revenues (line 1 minus line 2)	)			70, 434, 445	3.00
4.00	Less total operating expenses (from Wkst.	G-2, Part II, line	13)		72, 368, 131	4.00
5.00	Net income from service to patients (line	3 minus line 4)			-1, 933, 686	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				-640, 357	7.00
8.00	Revenues from telephone and other miscella	aneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and g	guests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical	supplies to other th	nan patients		0	16.00
17.00	Revenue from sale of drugs to other than	patients			0	17.00
18.00	Revenue from sale of medical records and a	abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms	s, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops,	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	OTHER OPERATING REVENUE				1, 585, 213	24.00
24.01	OTHER NONOPERATING REVENUE				11, 429	24.01
24.02	RENTAL REVENUE				575, 319	24.02
25.00	Total other income (sum of lines 6-24)				1, 531, 604	25.00
26.00	, , ,				-402,082	26.00
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	. ,	subscripts)			0	28.00
	Net income (or loss) for the period (line	1 /			-402,082	
	· · · · · · ·			I		

	Financial Systems		JOHNSON MEMOR			In Lie	u of Form CMS-:	2552-10
ANALYS	SIS OF HOSPITAL-BASED HOME HEALT	H AGENCY COSTS				Period: From 01/01/2015		
				HHA CCN:	15-7510	Го 12/31/2015	Date/Time Pre 1/16/2018 2:5	
						Home Health	PPS	
		Sal ari es	Employee	Transportati or	Contracted/Pu	Agency I Other Costs	Total (sum of	
			Benefits	(see	chased		cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS	1	1					
1.00	Capital Related - Bldg. & Fixtures			C	)	0	0	1.00
2.00	Capital Related - Movable			C		0	0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0			0 0	0	3.00
4.00	Transportati on	0	-	-			0	1
5.00	Administrative and General	195, 390	0	64, 766	b (	104, 709	364, 865	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	270, 473	0	C		0 0	270, 473	6.00
7.00	Physical Therapy	125, 101	0	-		0 0		
8.00 9.00	Occupational Therapy Speech Pathology	85, 354 4, 074		-			85, 354 4, 074	1
10.00	Medical Social Services	559		C			559	1
11.00	Home Heal th Ai de	485		-		0	485	
12.00 13.00	Supplies (see instructions) Drugs	0		-		0 10, 133 0 0		1
14.00	DME	0		C		0	0	1
15.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	C		0 0	0	15.00
16.00	Respiratory Therapy	0	-	-			-	
17.00	Private Duty Nursing	0	0	C		0 0	0	
18.00 19.00	Clinic Health Promotion Activities	0	0				0	
20.00	Day Care Program	0	0				0	1
21.00	Home Delivered Meals Program	0	0	C		0	0	
22. 00 23. 00	Homemaker Service All Others (specify)		0				0	
23.50	Tel emedi ci ne	0	0	-		5	0	23.50
24.00	Total (sum of lines 1-23)	681, 436 Recl assi fi cati		64,766 Adjustments	Net Expenses	0 114, 842	861, 044	24.00
		on	Tri al Balance	Aujustments	for Allocation	n		
			(col. 6 + col.7)		(col. 8 + col. 9)			
		7.00	8.00	9.00	10.00	_		-
1 00	GENERAL SERVICE COST CENTERS						•	1 00
1.00	Capital Related - Bldg. & Fixtures	0	0	C		0		1.00
2.00	Capital Related - Movable	0	0	C		D		2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportati on	0		C	) (			4.00
5.00	Administrative and General	0	364, 865	C	364, 86	5		5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	0	270, 473	C	270, 473	3		6.00
7.00	Physical Therapy	0						7.00
8.00 9.00	Occupational Therapy Speech Pathology	0						8.00 9.00
9.00 10.00	Medical Social Services	0	4,074		559			10.00
11.00	Home Health Aide	0	485		48			11.00
12.00 13.00	Supplies (see instructions) Drugs	0	10, 133 0		) 10, 133			12.00 13.00
14.00	DME	0						14.00
15 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services			C				15.00
15.00 16.00	Respiratory Therapy	0						15.00 16.00
17.00	Private Duty Nursing	0	-	-		0		17.00
18.00 19.00	Clinic Health Promotion Activities	0	0					18.00 19.00
	Day Care Program	0	0			Ď		20.00
	Home Delivered Meals Program	0	-	C				21.00
	Homemaker Service All Others (specify)	0	0					22.00 23.00
23.50	Tel emedi ci ne	0	0	C		D		23.50
24.00	Total (sum of lines 1-23)	0	861, 044	C	861, 044	1		24.00

	Financial Systems		JOHNSON MEMORIA	AL_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HHA GENERAL SERVICE	COST		Provider C		Period: From 01/01/2015	Worksheet H-1 Part I	
				HHA CCN:		To 12/31/2015		pared:
						Home Health	PPS	z pili
						Agency I		
			Capital Rela	ited Costs				
		Net Expenses	BIdgs &	Movabl e	Plant	Transportation	Subtotal	1
		for Cost	Fixtures	Equi pment	Operation &		(cols. 0-4)	
		Allocation (from Wkst. H.			Mai ntenance			
		col . 10)						
		0	1.00	2.00	3.00	4.00	4A. 00	
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0		1		0	1.00
1.00	Fixtures	Ŭ	0				0	
2.00	Capital Related - Movable	0		0			0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0		0	0	3.00
4.00	Transportation	0	Ö	0		0 0	, i i i i i i i i i i i i i i i i i i i	4.00
5.00	Administrative and General	364, 865	0	0		0 0	364, 865	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	270, 473	0	0		0 0	270, 473	6.00
7.00	Physical Therapy	125, 101	0	0		0 0	125, 101	•
8.00	Occupational Therapy	85, 354	0	0		0 0	85, 354	8.00
9.00	Speech Pathology	4,074	0	0		0 0	4,074	
10.00 11.00	Medical Social Services Home Health Aide	559 485		0			559 485	•
12.00	Supplies (see instructions)	10, 133	0	0		0 0	10, 133	•
13.00	Drugs	0	0	0		0	0	
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14.00
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	
17.00	Private Duty Nursing	0	0	0		0 0	0	
18.00 19.00	Clinic Health Promotion Activities	0	0	0			0	
20.00	Day Care Program	0	0	0		0 0	0	•
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
23.00 23.50	All Others (specify) Telemedicine	0	0	0		0 0	0	
	Total (sum of lines 1-23)	861, 044	0	0		0 0	861, 044	•
		Administrative						
		& General 5.00	<u>4A + 5)</u> 6.00					+
	GENERAL SERVICE COST CENTERS	5.00	0.00		-			
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable							2.00
2.00	Equi pment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00 5.00	Transportation Administrative and General	364, 865						4.00
5.00	HHA REI MBURSABLE SERVI CES	304, 803						5.00
6.00	Skilled Nursing Care	198, 892						6.00
7.00	Physical Therapy	91, 993						7.00
8.00 9.00	Occupational Therapy Speech Pathology	62, 765 2, 996	148, 119 7, 070					8.00 9.00
10.00	Medical Social Services	411	970					10.00
11.00	Home Heal th Aide	357	842					11.00
12.00 13.00	Supplies (see instructions)	7, 451 0	17, 584 0					12.00 13.00
13.00	Drugs DME	0	0					13.00
	HHA NONREI MBURSABLE SERVI CES							1
15.00	Home Dialysis Aide Services	0	0					15.00
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0					16.00 17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
	Home Delivered Meals Program	0	0					21.00
21.00	Homemaker Service							
22.00	Homemaker Service All Others (specify)	0	0 0					23.00
22. 00 23. 00 23. 50		0						•

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provider C HHA CCN:	CN: 15-0001 15-7510	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Pre 1/16/2018 2:5	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	Transportati (MI LEAGE)	onReconciliation	Administrative & General (ACCUM. COST)	-
		1.00	2.00	3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS					-		
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related – Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	C		0		3.00
4.00	Transportation (see	l o	0	Ċ		0		4.00
	instructions)	-	-			-		
5.00	Administrative and General	0	0	C		0 -364,865	496, 179	5.00
	HHA REIMBURSABLE SERVICES	•						1
6.00	Skilled Nursing Care	0	0	C	)	0 0	270, 473	6.00
7.00	Physical Therapy	0	0	C		0 0	125, 101	7.00
8.00	Occupational Therapy	0	0	C		0 0	85, 354	8.00
9.00	Speech Pathology	0	0	C		0 0	4,074	9.00
10.00	Medical Social Services	0	0	C		0 0	559	10.00
11.00	Home Health Aide	0	0	C		0 0	485	11.00
12.00	Supplies (see instructions)	0	0	C		0 0	10, 133	12.00
13.00	Drugs	0	0	C		0	0	13.00
14.00	DME	0	0	C		0 0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	C	)	0 0	0	15.00
16.00	Respiratory Therapy	0	0	C	)	0 0	0	16.00
17.00	Private Duty Nursing	0	0	C	)	0 0	0	17.00
18.00	Clinic	0	0	C	)	0 0	0	18.00
19.00	Health Promotion Activities	0	0	C		0 0	0	19.00
20.00	Day Care Program	0	0	C		0 0	0	20.00
21.00	Home Delivered Meals Program	0	0	C		0 0	0	21.00
22.00	Homemaker Service	0	0	C	)	0 0	0	22.00
	All Others (specify)	0	0	C		0 0	0	
23.50	Tel emedi ci ne	0	0	C		0 0	0	
24.00	Total (sum of lines 1-23)	0	0	C		0 -364, 865		
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	C		0	364, 865	25.00
26.00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 0000	00	0. 735350	26.00

LOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider C		Period: From 01/01/2015	Worksheet H-2 Part I	
				HHA CCN:		o 12/31/2015		pare 2 pr
						Home Health Agency I	PPS	
			CAPI	TAL RELATED CO	DSTS			
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	BLDG & FIXT - TOWER	MVBLE EQUIP	BENEFI TS	COMMUNI CATI ONS	
		0	1.00	1.01	2.00	DEPARTMENT 4.00	4.01	
0	Administrative and General	0	8, 540	0	733	42, 929	8, 066	
0	Skilled Nursing Care	469, 365	0	0	C C		0	2
0 0	Physical Therapy Occupational Therapy	217, 094 148, 119	0	0		27, 486 18, 753	0	3
0	Speech Pathol ogy	7,070	0	0		895	0	5
0	Medi cal Soci al Servi ces	970	0	0	C C	123	0	6
0	Home Health Aide	842	0	0	C	107	0	7
0	Supplies (see instructions)	17, 584	0	0	C	0 0	0	8
0	Drugs	0	0	0	0	0	0	9
00	DME Home Dialysis Aide Services	0	0	0			0	10   11
00	Respiratory Therapy	0	0	0		0	0	12
00	Private Duty Nursing	0	0	0	C	0	0	
00	Clinic	0	0	0	C	0 0	0	
00	Health Promotion Activities	0	0	0	0	0	0	
00	Day Care Program Home Delivered Meals Program	0	0	0			0	
00	Homemaker Service	0	0	0		0	0	
00	All Others (specify)	0	0	0	C	0	0	
50	Tel emedi ci ne	0	0	0	C	0	0	19
00	Total (sum of lines 1-19) (2)	861, 044	8, 540	0	733	149, 716	8, 066	
00	Unit Cost Multiplier: column							21
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	DATA PROCESSI NG	MATERI ALS	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	ADMI NI STRATI VE & GENERAL	
		4. 02	MANAGEMENT 4.03	4.04	4.05	4A. 05	5. 00	
0	Administrative and General	0	863	7, 217	21, 290		6, 168	
0 0	Skilled Nursing Care	0	0	0		528, 788 244, 580		
0	Physical Therapy Occupational Therapy	0	0	0		166, 872		
5	Speech Pathol ogy	0	0	0		7, 965		
C	Medical Social Services	0	0	0	C	1, 093	75	6
C	Home Health Aide	0	0	0	C	949	65	
)	Supplies (see instructions)	0	0	0		17, 584	1, 210	
) )()	Drugs DME	0	0	0			0	
00	Home Dialysis Aide Services	0	0	0			0	
00	Respiratory Therapy	0	0	0	C C	0	0	
00	Private Duty Nursing	0	0	0	C	0	0	13
	Clinic	0	0	0	C	0	0	
	Health Promotion Activities Day Care Program	0	0	0		0	0	
00		0		0			0	
00 00	5		9	0			0	
00 00 00	Home Delivered Meals Program	0	ol	0			Ů	
00 00 00 00	5	0	0 0	0	c c	0	0	1 1 2
00 00 00 00 00 50	Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	0	0 0 0	0			0	19
00 00 00 00 00 50 00	Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0 0	0 0 0 863	0 0 0 7, 217	C C 21, 290		0	19 20
00 00 00 00 00 50 00	Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0 0 0	0 0 0 863	0 0 0 7, 217	0 0 0 21, 290	0 0 1,057,469 0.000000	0	19
00 00 00 00 00 50	Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	0 0 0 0	0 0 863	0 0 7, 217	0 0 21, 290		0	19 20

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

LLOCAT	ION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS	Provider CC		Period: From 01/01/2015	Worksheet H-2 Part I	
				HHA CCN:		To 12/31/2015		pared 2 pm
						Home Health	PPS	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	Agency I CAFETERI A	NURSI NG	
		PLANT	LINEN SERVICE				ADMI NI STRATI ON	
. 00	Administrative and General	7.00 18,395	8.00	9.00	10.00	11.00 0 17,260	13.00 0	1.0
	Skilled Nursing Care	10, 343	0	0, 332		0 17,200		
00 F	Physical Therapy	0	0	0		0 C	0	3. (
	Occupational Therapy	0	0	0		0 0	0	
	Speech Pathology Medical Social Services	0	0	0			0	
	Home Health Aide	0	0	0		0 0	0	7.
00 5	Supplies (see instructions)	0	0	0		0 C	0	8.
	Drugs	0	0	0		0 0	-	
	DME Home Dialysis Aide Services		0	0			0	10.
	Respiratory Therapy	0	0	0		0 0	-	12.
	Private Duty Nursing	0	0	0		0 C	-	
	Clinic Health Promotion Activities	0	0	0			0	14. 15.
	Day Care Program	0	0	0			0	15.
	Home Delivered Meals Program	0	0	0		0 0	0	17.
	Homemaker Service	0	0	0		0 C	0	18.
	All Others (specify) Felemedicine	0	0	0			0	19. 19.
	Total (sum of lines 1-19) (2)	18, 395	0	6, 332		0 17,260	-	20.
	Jnit Cost Multiplier: column	10,070	J	0,002		.,,200		21.
	26, line 1 divided by the sum							
	of column 26, line 20 minus column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Intern &	Subtotal	
		SERVICES & SUPPLY		RECORDS & LI BRARY		Residents Cost & Post		
						Stepdown		
		14.00	15.00	14.00	24.00	Adjustments	26.00	
00 4	Administrative and General	14.00 0	15.00	16.00 11,523	24.00 149,31	25.00 6 C	26.00 149,316	1.
	Skilled Nursing Care	0	0	0	565, 17			
	Physical Therapy	0	0	0	261, 40		==.,	
	Occupational Therapy Speech Pathology	0	0	0	178, 35 8, 51		178, 354 8, 513	
	Medical Social Services	0	0	0	1, 16		1, 168	
)0  F	Home Health Aide	0	0	0	1, 01		1,014	
	Supplies (see instructions)	0	0	0	18, 79		18, 794	
] 00 ] 00	)rugs DMF	0	0	0			0	
	Home Dialysis Aide Services	0	0	0			0	
00 F	Respiratory Therapy	0	0	0		0 C	0	12.
	Private Duty Nursing	0	0	0		0 0	0	
	Clinic Health Promotion Activities		0	0			0	
	Day Care Program	0	0	0			0	
00	Home Delivered Meals Program	0	0	0		0 C	0	17.
	Homemaker Service	0	0	0			0	
	All Others (specify) Felemedicine	0	0	0			0	19. 19.
	Total (sum of lines 1-19) (2)	0	0	11, 523		-	-	
00 L	Jnit Cost Multiplier: column							21.
12	26, line 1 divided by the sum of column 26, line 20 minus							
						1		
C	column 26, line 1, rounded to							

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	Financial Systems		JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS	FO HHA COST CEN	TERS	Provider CCN HHA CCN:	N: 15-0001 15-7510	Period: From 01/01/2015 To 12/31/2015	Worksheet H-2 Part I Date/Time Pre	pared:
							1/16/2018 2:5	2 pm
						Home Health	PPS	
	Cast Caster Description					Agency I		
	Cost Center Description	Allocated HHA	Total HHA					
		A&G (see Part	Costs					
		27.00	28,00			-		
1.00	Administrative and General	27.00	20.00					1.00
2.00	Skilled Nursing Care	81, 580	646, 752					2.00
2.00	Physical Therapy	37,734	299, 143					2.00 3.00
4.00	Occupational Therapy	25, 745	204, 099					4.00
4.00 5.00	Speech Pathol ogy	1, 229	9, 742					4.00 5.00
6.00	Medical Social Services	1, 229	1, 337					6.00
7.00	Home Heal th Aide	146	1, 160					7.00
8.00	Supplies (see instructions)	2, 713	21, 507					8.00
9.00	Drugs	2,713	21, 507					9,00
7.00 10.00	DME	0	0					9.00 10.00
11.00	Home Dialysis Aide Services	0	0					10.00
12.00	Respiratory Therapy	0	0					12.00
12.00	Private Duty Nursing	0	0					12.00
14.00	Clinic	0	0					13.00
14.00	Health Promotion Activities	0	0					14.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
17.00	Homemaker Service	0	0					17.00
18.00	All Others (specify)	0	0					18.00
19.00	Tel emedicine	0	0					19.00 19.50
20.00	Total (sum of lines 1-19) (2)	149, 316	1, 183, 740					20.00
20.00	Unit Cost Multiplier: column	0, 144347	1, 103, 740					20.00
21.00	26, line 1 divided by the sum	0. 144347						21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
		1 1	I					

⁽¹⁾ Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATISTICA	AL Provider C		Period:	Worksheet H-2	
BASI S				HHA CCN:		From 01/01/2015 To 12/31/2015	Part II Date/Time Pre 1/16/2018 2:5	pared: 2 pm
						Home Health Agency I	PPS	
		CAPI	TAL RELATED CO	ISTS		Agency		
	Cost Center Description	BLDG & FIXT	BLDG & FIXT -	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	DATA	-
		(TOTAL FEET)	TOWER	(DOLLAR VALUE)	BENEFITS		PROCESSI NG	
			(SQUARE FEET)		DEPARTMENT (GROSS	(# NON PT P HONES)	(WORK ORDER S)	
					SALARI ES)			
1.00	Administrative and General	1.00 1,305	1.01	2.00	4.00	4.01	4.02	1.00
2.00	Skilled Nursing Care	0	-	0			0	
3.00	Physical Therapy	0	0	0			0	
4.00 5.00	Occupational Therapy Speech Pathology	0	0	0			0	1
6.00	Medical Social Services	0	0	0			0	
7.00	Home Health Aide	0	0	0	48	5 0	0	7.00
8.00	Supplies (see instructions)	0	0	0		0 0	0	
9.00 10.00	Drugs DME	0	0	0		0 0	0	9.00 10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00 14.00	Private Duty Nursing Clinic	0	0	0		0 0	0	
15.00	Health Promotion Activities	0	0	0		0 0	0	1
16.00	Day Care Program	0	0	0		0 0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0 0	0	17.00
18.00 19.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	18.00 19.00
19.50	Tel emedi ci ne	0	0	0		0 0	0	19.50
20.00	Total (sum of lines 1-19)	1, 305		730			0	20.00
21.00	Total cost to be allocated Unit cost multiplier	8, 540 6. 544061	0 0. 000000	733 1. 004110			0 0. 000000	
22100	Cost Center Description	MATERIALS	ADMI TTI NG			nADMI NI STRATI VE		22100
		MANAGEMENT	(GROSS CHAR	ACCOUNTI NG		& GENERAL	PLANT	
		(SUPPLY USA GE)	GES)	(GROSS CHAR GES)		(ACCUM. COST)	(TOTAL FEET)	
	1	4.03	4.04	4.05	5A	5.00	7.00	
1.00 2.00	Administrative and General Skilled Nursing Care	14, 318	1, 656, 312	1, 656, 312 0		0 89,638 0 528,788	1, 305 0	1.00 2.00
3.00	Physical Therapy	0	0	0		0 244, 580	0	
4.00	Occupational Therapy	0	0	0		0 166, 872	0	1
5.00 6.00	Speech Pathology Medical Social Services	0	0	0		0 7,965 0 1,093	0	
7.00	Home Health Aide	0	0	0		0 1, 093 0 949	0	
8.00	Supplies (see instructions)	0	0	0		0 17, 584	0	8.00
9.00	Drugs	0	0	0		0 0	0	
10.00 11.00	DME Home Dialysis Aide Services	0	0	0		0 0	0	
12.00	Respiratory Therapy	0	0	0		0 0	0	
13.00	Private Duty Nursing	0	0	0		0 0	0	
14.00 15.00	Clinic Health Promotion Activities	0	0	0		0 0	0	
16.00	Day Care Program	0	0	0		0 0	0	1
17.00	Home Delivered Meals Program	0	0	0		0 0	0	
18.00 19.00	Homemaker Service All Others (specify)	0	0	0		0 0 0 0	0	
19.00	Telemedicine	0	0	0		0 0	0	
20.00	Total (sum of lines 1-19)	14, 318		1, 656, 312		1, 057, 469		20.00
21.00	Total cost to be allocated Unit cost multiplier	863 0. 060274		21, 290		72, 761 0. 068807		21.00
22.00		0.000274	0.004357	0. 012854	I	0.000807	14.070/80	∠∠. UU

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	JOHNSON MEMORI TERS STATISTICA		CN: 15-0001	Peri od:	u of Form CMS-2 Worksheet H-2	
BASIS			HHA CCN:	15-7510	From 01/01/2015 To 12/31/2015	Part II	pared:
					Home Health Agency I	PPS	
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDR)	HOUSEKEEPING (TOTAL FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS PAI D	NURSI NG	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
<ul> <li>1.00 Administrative and General</li> <li>2.00 Skilled Nursing Care</li> <li>3.00 Physical Therapy</li> <li>4.00 Occupational Therapy</li> <li>5.00 Speech Pathology</li> <li>6.00 Medical Social Services</li> <li>7.00 Home Health Aide</li> <li>8.00 Supplies (see instructions)</li> <li>9.00 Drugs</li> <li>10.00 DME</li> <li>11.00 Home Dialysis Aide Services</li> <li>12.00 Respiratory Therapy</li> <li>13.00 Private Duty Nursing</li> <li>14.00 Clinic</li> <li>15.00 Home Delivered Meals Program</li> <li>18.00 Homemaker Service</li> <li>19.00 All Others (specify)</li> <li>19.50 Telemedicine</li> <li>20.00 Unit cost nultiplier</li> <li>Cost Center Description</li> </ul>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		22, 0 22, 0 17, 2 0. 7838	0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0		2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00 21.00
	REQUI S. )	LI BRARY (GROSS CHAR GES) 16.00					
<ol> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>O Skilled Nursing Care</li> <li>O Coupational Therapy</li> <li>O Cocupational Therapy</li> <li>Speech Pathology</li> <li>Medical Social Services</li> <li>Home Heal th Aide</li> <li>Supplies (see instructions)</li> <li>O Drugs</li> <li>O Home Dialysis Aide Services</li> <li>O Home Dialysis Aide Services</li> <li>O Respiratory Therapy</li> <li>O Clinic</li> <li>O Day Care Program</li> <li>O Home Dialvered Meals Program</li> <li>O Home Dialvered Meals Program</li> <li>O Home Dial vered Meals Program</li> <li>O Home Dial vered Meals Program</li> <li>O Home Service</li> <li>O All Others (specify)</li> <li>O Total (sum of lines 1-19)</li> <li>O Total cost to be allocated</li> <li>O Unit cost multiplier</li> </ol>		1, 656, 312 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00 21.00

	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provider C		Period:	Worksheet H-3 Part I	
				HHA CCN:		From 01/01/2015 To 12/31/2015		
				Title	e XVIII	Home Health Agency I	PPS	I ⁻
	Cost Center Description		Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst. H-2, Part I)	Ancillary Costs (from	Costs (col s. + 2)	1	Per Visit (col. 3 ÷ col.	
				Part II)			4)	
	PART I - COMPUTATION OF LESSER			2.00		4.00	5.00	
	BENEFICIARY COST LIMITATION						·	
1.00	Cost Per Visit Computation Skilled Nursing Care	2.00	646, 752		646, 752	2 3, 509	184. 31	1.00
2.00	Physical Therapy	3.00		C				2.00
3.00	Occupational Therapy	4.00		C				3.00
4.00	Speech Pathology	5.00		C	-			4.00
5.00 6.00	Medical Social Services Home Health Aide	6. 00 7. 00			1, 33		222. 83 38. 67	5.00 6.00
7.00	Total (sum of lines 1-6)	7.00	1, 160 1, 162, 233	C				7. OC
7.00			1, 102, 233		Program Visits			7.00
						rt B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to			
					Deductibles &	Deducti bl es		
		0	1.00	2.00	Coi nsurance 3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		18020	C				8.00
8.01	Skilled Nursing Care Skilled Nursing Care		26900 50032	C		7		8. 01 8. 02
8.02 9.00	Physical Therapy		18020	(				8.02 9.00
9.01	Physical Therapy		26900	(	-			9.01
9.02	Physical Therapy		50032	C				9.02
10.00	Occupational Therapy		18020	C	84	1		10.00
	Occupational Therapy		26900	C				10. 01
	Occupational Therapy		50032	C				10.02
11.00	Speech Pathology		18020 26900	0		9		11.00 11.01
	Speech Pathol ogy Speech Pathol ogy		50032			2		11.01
12.00	Medical Social Services		18020	(				12.00
	Medical Social Services		26900	C				12.01
12.02	Medical Social Services		50032	C		1		12.02
	Home Health Aide		18020	C				13.00
	Home Health Aide		26900	C		D		13.01
	Home Health Aide Total (sum of lines 8–13)		50032	(				13.02 14.00
14.00		From Wkst. H-2	Facility Costs	Shared	Total HHA		Ratio (col. 3	14.00
		Part I, col.	(from Wkst.	Ancillary	Costs (col s.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
		0	1.00	<u>Part II)</u> 2.00	3.00	4.00	5.00	
1	Supplies and Drugs Cost Computa		1.00	2.00	3.00	4.00	5.00	
	Cost of Medical Supplies	8.00		C			0. 000000	
16.00	Cost of Drugs	9.00	0 Program Visits		Cost of	0 0	0. 000000	16.00
					Services			
			Part			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &	Subject to	Part A	Not Subject to Deductibles &	Subject to Deductibles &	
				Deductibles a		Deductibles a		
				Coi nsurance		Coi nsurance	i coinsurance i	
		6.00	Coi nsurance 7.00	Coi nsurance 8.00	9.00	Coi nsurance 10.00	Coi nsurance 11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION		Coi nsurance 7.00	8.00		10.00	11.00	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, A	8.00	E PROGRAM LI MI	10.00 TATION COST, OF	11.00	
1.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, A0 1,660	8.00	E PROGRAM LI MI	10.00 TATI ON COST, OF 0 305,955	11.00	
1.00 2.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	OF AGGREGATE F	Coi nsurance 7.00 PROGRAM COST, A0 1,660 1,021	8.00	E PROGRAM LI MI	10. 00 TATI ON COST, OF 0 305, 955 0 156, 632	11.00	2.00
1.00 2.00 3.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AC 1,660 1,021 740	8.00	E PROGRAM LI MI	10.00 TATI ON COST, OF 305,955 156,632 124,202	11.00	2.00 3.00
1.00 2.00 3.00 4.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AC 1,660 1,021 740 18	8.00	E PROGRAM LIMI	10.00 TATI ON COST, OF 305,955 156,632 124,202 2,579	11.00	2.00 3.00 4.00
1.00 2.00 3.00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	OF AGGREGATE F	Coinsurance 7.00 PROGRAM COST, AU 1,660 1,021 740 18 4	8.00	E PROGRAM LI MI	10.00 TATI ON COST, OF 305,955 156,632 124,202	11.00	1.00 2.00 3.00 4.00 5.00 6.00

	Financial Systems TONMENT OF PATLENT SERVICE COST	- <u>s</u>	JOHNSON MEMOR	AL HOSPITAL	°N: 15_0001	In Lie Period:	u of Form CMS- Worksheet H-3	
AFFORT	FORMENT OF FATENT SERVICE COST	5		HHA CCN:	15-7510	From 01/01/2015 To 12/31/2015	Part I	epared:
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	( 00	7.00	0.00	0.00		11.00	
	Limitation Cost Computation	6.00	7.00	8.00	9.00	10.00	11.00	
$\begin{array}{c} 8.\ 00\\ 8.\ 01\\ 8.\ 02\\ 9.\ 00\\ 9.\ 01\\ 9.\ 02\\ 10.\ 00\\ 10.\ 01\\ 10.\ 02\\ 11.\ 00\\ 11.\ 01\\ 11.\ 02\\ 12.\ 00\\ 12.\ 01\\ \end{array}$	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services							8.00 8.01 8.02 9.00 9.01 9.02 10.00 10.01 10.02 11.00 11.01 11.02 12.00 12.01
12.02 13.00 13.01 13.02 14.00	Medical Social Services Home Health Aide Home Health Aide Home Health Aide Total (sum of lines 8–13)	Prog	ram Covered Cha	iraes	Cost of			12.02 13.00 13.01 13.02 14.00
				3	Servi ces			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance		Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	_
15.00	Supplies and Drugs Cost Computa Cost of Medical Supplies		0	0		0 0	C	15.00
16.00	Cost of Drugs		0			0	0	
	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
	PART I - COMPUTATION OF LESSER	12.00					)	
	BENEFICIARY COST LIMITATION	OF AGGREGATE F	RUGRAW CUST, A	GGREGATE OF TH	E PROGRAW LI	WITATION COST, OF	< c	
	Cost Per Visit Computation	T	T					
1.00	Skilled Nursing Care	305, 955						1.00
2.00	Physical Therapy	156, 632						2.00
3.00 4.00	Occupational Therapy Speech Pathology	124, 202 2, 579						3.00 4.00
5.00	Medical Social Services	891						5.00
6.00	Home Health Aide	1, 160						6.00
7.00	Total (sum of lines 1-6)	591, 419						7.00
	Cost Center Description							-
	Limitation Cost Computation	12.00						
8.00	Skilled Nursing Care	1						8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8. 02
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
10.00	Occupational Therapy							10.00
10. 01 10. 02	Occupational Therapy Occupational Therapy							10.01
11.00	Speech Pathol ogy							11.00
11.01	Speech Pathol ogy							11.01
11.02	Speech Pathology							11.02
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02 14.00	Home Health Aide Total (sum of lines 8–13)							13.02 14.00
17.00		I	I.					1 17.00

Health Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0001	Peri od:	Worksheet H-3	
			HHA CCN:	15-7510	From 01/01/2015 To 12/31/2015		narod
			TITA CON.	15-7510	10 12/31/2015	1/16/2018 2:5	
			Title	e XVIII	Home Health	PPS	
					Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Rati o	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66.00	0. 407166	C	)	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 216175	C		0 col. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 319742	C		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 439113	C		0 col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 427762	C		0 col. 2, line 1	6. 00	5.00

	Financial Systems JOHNSON MEMORIAL ATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	N: 15-0001	Peri od:	worksheet H-4	
		HHA CCN:	15-7510	From 01/01/2015 To 12/31/2015	Part I-II	epare
		Title	XVIII	Home Health	PPS	iz pi
				Agency I Par	TT B	
			Part A	Not Subject to		
				Coi nsurance	Coi nsurance	
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTON	MARY CHARGES	5			
	Reasonable Cost of Part A & Part B Services					
0 0	Reasonable cost of services (see instructions) Total charges			0 0 0 0		
0	Customary Charges			0 0	0	4
0	Amount actually collected from patients liable for payment for	servi ces		0 0	0	
	on a charge basis (from your records)			-	-	
00	Amount that would have been realized from patients liable for	payment		0 0	0	4
	for services on a charge basis had such payment been made in a	ccordance				
	with 42 CFR §413.13(b)		0.000			
0	Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions)		0.0000	-		
0	Excess of total customary charges over total reasonable cost (	complete				
0	only if line 6 exceeds line 1)	comprete		0 0	0	
0	Excess of reasonable cost over customary charges (complete only	y if line		0 0	0	
	1 exceeds line 6)					
0	Primary payer amounts			0 0	-	
				Part A	Part B	
				Servi ces 1.00	Services 2.00	-
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
00	Total reasonable cost (see instructions)			0	0	1(
00	Total PPS Reimbursement - Full Episodes without Outliers			0	,	
00	Total PPS Reimbursement - Full Episodes with Outliers			0	5, 834	
00	Total PPS Reimbursement - LUPA Episodes			0	.,	
00 00	Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	1, 378 223	
00	Total PPS Outlier Reimbursement - PEP Episodes			0	223	
00	Total Other Payments			0	0	
00	DME Payments			0	0	
00	Oxygen Payments			0	0	1
00	Prosthetic and Orthotic Payments			0	0	
00	Part B deductibles billed to Medicare patients (exclude coinsu	rance)			0	
00	Subtotal (sum of lines 10 thru 20 minus line 21)			0		
~~	Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23)			0	0 656, 274	
				0	030,274	
00	, , ,					
00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)			0		
00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)			0	-	2
00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins	structions)		0	656, 274	2 2 2
00 00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line	structions) 27)		0	656, 274 656, 274	20 21 28 29
00 00 00 00 00 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER	27)		0	656, 274 656, 274 -1, 614	20 21 28 20 30
00 00 00 00 00 00 00 50	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER Pioneer ACO demonstration payment adjustment (see instructions)	27)		000000000000000000000000000000000000000	656, 274 656, 274 -1, 614 0	20 21 28 20 30 30
00 00 00 00 00 00 50 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	27)		0 0 0 0 0	656, 274 656, 274 -1, 614 0 654, 660	20 21 20 30 30 31
00 00 00 00 00 00 50 00 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)	27)		0 0 0 0 0 0 0	656, 274 656, 274 -1, 614 0 654, 660 13, 093	20 27 28 30 30 31 31
00 00 00 00 00 00 50 00 00 01 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	27)		0 0 0 0 0 0 0 0 0	656, 274 656, 274 -1, 614 0 654, 660 13, 093 641, 567	26 27 28 30 30 31 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)	27)		0 0 0 0 0 0 0	656, 274 -1, 614 0 654, 660 13, 093 641, 567 0	26 27 28 30 30 31 31 32 33

	SIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED	Provider C	CN: 15-0001		eriod:	Worksheet H-5	
PRO	OGRAM BENEFI CI ARI ES	HHA CCN:	15-7510	T	rom 01/01/2015 0 12/31/2015	Date/Time Prep 1/16/2018 2:52	
					Home Health Agency I	PPS	<u> piii</u>
		I npati en	t Part A			t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
	Tatal intenin normante paid to provider	1.00	2.00	0	3.00	4.00	1
00 00	Total interim payments paid to provider 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		641, 567 0	1. 2.
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) Program to Provider						3.
01				0		0	3.
)2				0		0	3.
)3				0		0	3
)4				0		0	3
)5	Provider to Program			0		0	3
0				0		0	3
1				0		0	3
2				0		0	3
3				0		0	3
64 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0	3 3
'	3. 50-3. 98)			Ŭ		0	0
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		641, 567	4
	TO BE COMPLETED BY CONTRACTOR						
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
	Program to Provider		1	- 1			_
)1 )2				0		0	5 5
12				0		0	5
	Provider to Program		-	-		-	
0				0		0	5
1				0		0	5
2 9	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		0	5 5
0	5.50-5.98) Determined net settlement amount (balance due) based on			U		0	6
	the cost report. (1)						
)1	SETTLEMENT TO PROVIDER			0		0	6
)2	SETTLEMENT TO PROGRAM			0		0	6
00	Total Medicare program liability (see instructions)			U	Contractor	641,567 NPR Date	7
					Number	(Mo/Day/Yr)	
		(	)		1.00	2.00	

	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0001	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	
		Title XVIII	Hospi tal	1/16/2018 2:52 PPS	2 pm
				FFJ	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
00	Capital DRG other than outlier			398, 975	1.
01	Model 4 BPCI Capital DRG other than outlier			0	1.
00	Capital DRG outlier payments			1, 283	2.
	Model 4 BPCI Capital DRG outlier payments			0	
00	Total inpatient days divided by number of days in the cos	st reporting period (see inst	ructions)	15. 78	
00	Number of interns & residents (see instructions)			0.00	
00	Indirect medical education percentage (see instructions)			0.00	
00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)			0	6.
00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)		, part A line	0.00	
00	Percentage of Medicaid patient days to total days (see in	nstructions)		0.00	
	Sum of lines 7 and 8			0.00	
	Allowable disproportionate share percentage (see instruct	i ons)		0.00	
	Disproportionate share adjustment (see instructions)			0	
. 00	Total prospective capital payments (see instructions)			400, 258	12.
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
	Program inpatient routine capital cost (see instructions)			0	1 1.
00	Program inpatient ancillary capital cost (see instruction			0	2.
00	Total inpatient program capital cost (line 1 plus line 2)			Ő	3.
00	Capital cost payment factor (see instructions)			0	4.
00	Total inpatient program capital cost (line 3 x line 4)			0	
				1.00	
_	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
00	Program inpatient capital costs (see instructions)			0	1.
00	Program inpatient capital costs for extraordinary circums	stances (see instructions)		0	2.
00	Net program inpatient capital costs (line 1 minus line 2)			0	3.
00	Applicable exception percentage (see instructions)			0.00	4.
00	Capital cost for comparison to payments (line 3 x line 4)			0	5.
00	Percentage adjustment for extraordinary circumstances (se	e instructions)		0.00	6.
00	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2 x	line 6)	0	7.
	Capital minimum payment level (line 5 plus line 7)			0	
	Current year capital payments (from Part I, line 12, as a			0	
00		to capital payments (line 8)		0	
00 . 00	Current year comparison of capital minimum payment level				11.
00 . 00 . 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)		, ,	0	
00 . 00 . 00 . 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita	nl payments (line 10 plus lin	ie 11)	0	12.
00 . 00 . 00 . 00 . 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita Current year exception payment (if line 12 is positive, e	I payments (line 10 plus lin enter the amount on this line	ue 11)	0	12. 13.
00 . 00 . 00 . 00 . 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov	I payments (line 10 plus lin enter the amount on this line	ue 11)	0	12. 13.
00 . 00 . 00 . 00 . 00 . 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line)	al payments (line 10 plus lin enter the amount on this line ver capital payment for the f	ue 11)	0 0 0	12. 13. 14.
. 00 . 00 . 00 . 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov	al payments (line 10 plus lin enter the amount on this line ver capital payment for the f e instructions)	ue 11)	0	12. 13. 14. 15.