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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHNSON MEMORIAL HOSPITAL (15-0001) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

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

(Si gned)	ADAM PUTVIN
	Officer or Administrator of Provider(s)
	CFO
T	ïtle

(Dated when report is electronically signed.)

Time:

4:01 pm

Date

			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	52, 632	-11, 670	0	-296, 272	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	1		0	9.00
200.00	Total	0	52, 632	-11, 669	0	-296, 272	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		MEMORI AL			: 15-0001	Period:		Works	orm CMS- sheet S-2	
							From 01/0 To 12/3	1/2019		/Time Pre	
	1.00	2.	00		3.00			4.00	8/27	/2020 4:0	U pm
	Hospital and Hospital Health Care Co	mplex Address:	(
	Street: 1125 WEST JEFFERSON STREET City: FRANKLIN	PO Box: State: I	N 7	ip Code	· 1612	1 Cour	nty: JOHNSO	4			1.
0	CITY. INANKEIN	Component Na		CCN	CBSA		- 1 ²		ent Sy	/stem (P,	Ζ.
			N	umber	Numbe	er Type	Certifie		, 0,		
		1.00		2.00	3.00	4.00	5.00	V 6. 00	XVI) 7.0		-
	Hospital and Hospital-Based Componen			2.00	5.00	4.00		10.00	///.0	0 0.00	
0	Hospi tal	JOHNSON MEMORIAL	1	50001	26900	0 1	07/01/19	56 N	P	0	3.
0 0 0 0 00 00	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital -Based SNF Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA	JOHNSON MEMORIAL	HOME 1	57510	26900	D	07/01/19	97 N	Ρ	Ν	4. 5. 6. 7. 8. 9. 10. 11. 12.
00 00 00 00 00	Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FOHC Hospital-Based (CMHC) I Renal Dialysis Other	HEALTH									13. 14. 15. 16. 17. 18. 19.
							Fro			To:	_
00	Cost Reporting Period (mm/dd/yyyy)						01/01			2.00 31/2019	20.
	Type of Control (see instructions)						9		12/		20.
						4 6 6				2 00	
	Inpatient PPS Information					1.00	2.0	0		3.00	
01 02	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re	r yes or "N" for 412.106(c)(2)(Pic r yes or "N" for compensated care mn 1, "Y" for yes riod occurring pi " for no for the er October 1. (so requires final u port settlement?	no. Is th ckle amenda no. payments s or "N" f rior to Oc portion o ee instruc uncompensa (see inst	is ment for thi or no f tober 1 f the c tions) ted car ructior	s For cost	Y	Ŷ				22.
03	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	er 1. Enter in co e cost reporting ic reclassificati ds for delineatin olumn 1, "Y" for g period prior to no for the portion er October 1. (so 100 but not more	olumn 2, " period on on from u ng statist yes or "N o October on of the ee instruc than 499	Y" for or aft ical ar " for r 1. Ente cost tions) beds (a	er no er	Ν	N			Ν	22.
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admission, 2 i of identifying th method used in th	f census ne days in ne prior c "N" for n In-State Medicaid	days, c this c ost o. In-St Medic	or 3 cost ate aid	Out-of State	3 N Out-of State	Medica HMO da		Other Medicaid	23.
			paid days	el i gi unpa day 2. 0	nid p vs	Medicaid baid days 3.00	Medi cai d el i gi bl e unpai d 4.00	5.00)	days 6. 00	
00	lf this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-state	180		, 010	0	0		342		0 24.

	Financial Systems JOHNSON TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D/	I MEMORIAL H	Provider CO	CN: 15-0001	Peri od:			eet S-2	
					From 01/0 To 12/3	01/2019 31/2019	Date/T		
		In-State	In-State	Out-of	Out-of	Medi ca	aid (<u>020 4:0</u>)ther	
		Medicaid paid days	Medicaid eligible	State Medicaid	State Medicaid	HMO da		di cai d days	
		paru uays	unpai d	paid days	eligible			uays	
			days		unpai d				_
5.00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.
5.00	Medicaid paid days in column 1, the in-state				Ū				20.
	Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state								
	Medicaid eligible unpaid days in column 4, Medicaid								
	HMO paid and eligible but unpaid days in column 5.				Urbon /		Date o	F Coogr	
						00		00	-
. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the be	ginning of	the	1			26.
7.00	Enter your standard geographic classification (not w		at the en	d of the co	st	1			27.
	reporting period. Enter in column 1, "1" for urban o	r"2" for r	ural. If a						
5.00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th			CH status i	n	0			35.
	effect in the cost reporting period.								
					Begi r	ni ng: 00	Endi 2	i ng: 00	-
5.00	Enter applicable beginning and ending dates of SCH s		cript line	e 36 for num		00	2.	00	36.
7 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente		r of perio	ds MDH stati	us	0			37.
	is in effect in the cost reporting period.		·			0			
7. 01	Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37.
	instructions)	01 903 01	N 101 110.	(300					
3. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o								38.
	enter subsequent dates.	i perious i	II excess u						
						/N		/N	_
9.00	Does this facility qualify for the inpatient hospita	l payment a	djustment	for low volu		00 V		00 V	39.
	hospitals in accordance with 42 CFR §412.101(b)(2)(i				mn				
	1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i				es				
	or "N" for no. (see instructions)	ŗ		5					
0.00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo					N		N	40.
	no in column 2, for discharges on or after October 1			J					
						V	XVIII 2.00		-
	Prospective Payment System (PPS)-Capital							-	
5.00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti ona	ite share in	accordanc	e N	N	N	45.
5.00	Is this facility eligible for additional payment exc					N	N	N	46.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I	II and Wks	st. L-1, Pt.	I through				
7.00	Is this a new hospital under 42 CFR §412.300(b) PPS					N	N	N	47.
	Is the facility electing full federal capital paymen Teaching Hospitals	t? Enter "	Y" for yes	or "N" for	no.	N	N	N	48.
	Is this a hospital involved in training residents in	approved (ME program	s? Enter "Y	" for yes	or N			56.
3. 00	"N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for			(or subseque	ent CR), M	A			
3. 00	If line 56 is yes, is this the first cost reporting			esidents in	approved				57.
3. 00 5. 00	GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon								
3.00 5.00	Is a dru residents start training in the mist non			51					
3. 00 5. 00	for yes or "N" for no in column 2. If column 2 is "			and comile					- E0
3. 00 5. 00 7. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I		or physicial		es as	N			58.
3. 00 5. 00 7. 00		bursement f		ans service					1
3. 00 6. 00 7. 00 3. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim	bursement f complete V	kst. D-5.	, Pt. I.		<u>N</u>		1	59.
3. 00 5. 00 7. 00 3. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f complete V	kst. D-5.	2, Pt. I. NAHE 413.8		neet A		hrough cati on	
3. 00 6. 00 7. 00 3. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f complete V	kst. D-5.	, Pt. I.			Qualifi Crite	ication erion	
8.00 6.00 7.00 8.00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f complete V	kst. D-5.	2, Pt. I. NAHE 413.8 Y/N	Lir	neet A e #	Qualifi Crite Cc	ication erion de	
8.00 6.00 7.00 8.00 9.00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f complete V <u>s, complete</u>	/kst. D-5. 9 Wkst. D-2	2, Pt. I. NAHE 413.8	Lir	neet A	Qualifi Crite Cc	ication erion	
8.00 6.00 7.00 8.00 9.00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413	bursement f complete V s, complete (NAHE) cos .85? (see	Kst. D-5. Wkst. D-2	2, Pt. I. NAHE 413.8 Y/N 1.00	Lir	neet A e #	Qualifi Crite Cc	ication erion de	59. 60.
 00 00 00 00 00 00 00 	"N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye	bursement f complete V s, complete (NAHE) cos .85? (see lumn 1. lf	kst. D-5. Wkst. D-2 ts for column 1	2, Pt. I. NAHE 413.8 Y/N 1.00	Lir	neet A e #	Qualifi Crite Cc	ication erion de	

0011	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		FI OVI del C		eriod: rom 01/01/2019 o 12/31/2019	Worksheet S-2 Part I Date/Time Pre 8/27/2020 4:0	pared
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.0
	column 1. (see instructions)						
1.01	Enter the average number of unweighted primary care						61.0
	FTEs from the hospital's 3 most recent cost reports						
	ending and submitted before March 23, 2010. (see instructions)						
1. 02	Enter the current year total unweighted primary care						61.0
	FTE count (excluding OB/GYN, general surgery FTEs,						
	and primary care FTEs added under section 5503 of ACA). (see instructions)						
1. 03	Enter the base line FTE count for primary care						61.0
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see						
1 04	instructions) Enter the number of unweighted primary care/or						61.0
1.04	surgery allopathic and/or osteopathic FTEs in the						01.
	current cost reporting period. (see instructions).						
1.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61.
	primary care and/or general surgery FTE counts (line						
	61.04 minus line 61.03). (see instructions)						
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.
	care or general surgery. (see instructions)						
		Pro	ogram Name	Program Code	Unweighted	Unwei ghted	
					IME FTE Count	Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
1. 10	Of the FTEs in line 61.05, specify each new program				0.00	0.00	61.
	special ty, if any, and the number of FTE residents						
	for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the						
	program code. Enter in column 3, the IME FTE						
	unweighted count. Enter in column 4, the direct GME						
1 20	FTE unweighted count.				0.00	0.00	61.
1.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0.00	0.00	01.
	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
	· · · · · · · · · · · · · · · · · · ·			1			
	ACA Provisions Affecting the Health Resources and Ser	rvi ces	Administration	(HRSA)		1.00	
2. 00	Enter the number of FTE residents that your hospital				iod for which	0.00	62.
	your hospital received HRSA PCRE funding (see instruc						
2.01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog				your hospital	0.00	62.0
	Teaching Hospitals that Claim Residents in Nonprovide			///3/			1
3.00	Has your facility trained residents in nonprovider se	ettings	during this c			Ν	63.
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lin	es 64 through		uctions) Unweighted	Datio (col	
				Unweighted FTEs	FTEs in	Ratio (col. 1/ (col. 1 +	
				Nonprovi der	Hospi tal	col. 2))	
				Site			-
	Section 5504 of the ACA Base Year FTE Residents in No	opprovi	der Settings-	1.00		<u>3.00</u>	
	period that begins on or after July 1, 2009 and befor			- This base year	is your cost	reporting	
. 00	Enter in column 1, if line 63 is yes, or your facilit	ty trai	ned residents	0.00	0.00	0. 000000	64.
	in the base year period, the number of unweighted nor						
	resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted						
				1	1		1
	resident FTEs that trained in your hospital. Enter in						

	EX IDENTIFICATION D	I MEMORIAL HOSPITAL ATA Provider C		eriod: com 01/01/2019	u of Form CMS- Worksheet S-2 Part I	
			Tc			epared
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0.00	0.00	0. 000000) 65.(
divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Nonprovider Site	nospi tai	(01.2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin	gsEffective f	or cost report	ing periods	
		ry care resident	0.00	0.00	0,00000	66 (
.00 Enter in column 1 the number of u FTEs attributable to rotations or Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	
.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in	rovider settings. ry care resident 3 the ratio of structions)	Unwei ghted	Unwei ghted	Ratio (col.	
.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in	rovider settings. ry care resident 3 the ratio of structions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in Program Name	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
 OD Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + OD 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) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see in</u> <u>Program Name</u> <u>1.00</u>	rovi der settings. ry care resident 3 the ratio of structions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	0 67.0
 .00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + .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 3 divided by (column 3 + column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) .00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see in</u> <u>Program Name</u> <u>1.00</u> <u>1.00</u>	rovider settings. ry care resident 3 the ratio of structions) Program Code 2.00 2.00 IPF), or does it con n approved GME teach	Unweighted FTEs Nonprovider Site 3.00 0.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most N	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	
.00 Enter in column 1 the number of u FTEs attributable to rotations of u Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + .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 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF .00	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see in Program Name 1.00 1.00 1.00 2.00 2.00 2.00 2.00 2.00	rovi der settings. ry care resident 3 the ratio of structions) Program Code 2.00 2.00 1PF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in yes or "N" for in s in a new teacl yes or "N" for in	Unweighted FTEs in Hospital 4.00 0.00 0.00 1.00 provider? N the most no. (see ning no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	

DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ovider CCN: 15-0001	Period: From 01/01/2 To 12/31/2	2019 2019	Workshe Part I Date/Ti 8/27/20	me Pre	pared:
		-	1.00	2.00	3.00	
6.00 If line 75 is yes: Column 1: Did the facility have an approved G recent cost reporting period ending on or before November 15, 20 no. Column 2: Did this facility train residents in a new teachin CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Col indicate which program year began during this cost reporting per	04? Enter "Y" for yes g program in accordar umn 3: If column 2 is	n the most or "N" for ice with 42 Y,	N	N	0	76.00
				1.0	0	
Long Term Care Hospital PPS 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and 1.00 Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no. TEFRA Providers		ng period? Er	nter	N N		80. 00 81. 00
 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEF 6.00 Did this facility establish a new Other subprovider (excluded un §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 			no.	N		85.00 86.00
7.00 Is this hospital an extended neoplastic disease care hospital cl 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	assified under sectio			N	/	87.00
		V 1.00		XI > 2. 0		
Title V and XIX Services					-	
0.00 Does this facility have title V and/or XIX inpatient hospital se yes or "N" for no in the applicable column.				Y		90.00
1.00 Is this hospital reimbursed for title V and/or XIX through the c full or in part? Enter "Y" for yes or "N" for no in the applicab 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual c	le column.	N		Y N		91.0
instructions) Enter "Y" for yes or "N" for no in the applicable 3.00 Does this facility operate an ICF/IID facility for purposes of t	column.	. N		N		93.0
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column.	"N" for no in the	N		Ν		94.0
5.00 If line 94 is "Y", enter the reduction percentage in the applica 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		0. 00 N		0. 0 N	0	95.0 96.0
 7.00 If line 96 is "Y", enter the reduction percentage in the applica 8.00 Does title V or XIX follow Medicare (title XVIII) for the intern stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for y column 1 for title V, and in column 2 for title XIX. 	s and residents post	0. 00 Y		0. 0 Y	0	97.0 98.0
8.01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title				Y		98.0
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the calcul bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N for title V, and in column 2 for title XIX.		Y		Y		98.0
8.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or				Ν		98. C
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reim outpatient services cost? Enter "Y" for yes or "N" for no in col in column 2 for title XIX.		N		Ν		98. C
B. 05 Does title V or XIX follow Medicare (title XVIII) and add back t Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.				Y		98. C
8. 06 Does title V or XIX follow Medicare (title XVIII) when cost reim Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 f column 2 for title XIX. Rural Providers		Y		Y		98.0
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-incl	usive method of payme	ent N				105. 0 106. 0
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF an Enter "Y" for yes or "N" for no in column 2. (see instructions)	(see instructions) train I&Rs in an d/or IRF unit(s)?	N				107.0
08.00 Is this a rural hospital qualifying for an exception to the CRNA CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	fee schedule? See 4	2 N				108.0

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 01/01/2019	Worksheet S- Part I	-2
		Te			
	Physi cal	Occupati onal	Speech	Respi ratory	
09.00 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.	<u>1.00</u> N	2.00 N	3. 00 N	4.00 N	109.0
				1.00	_
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes o	r "N" for no. I	f yes,	N	110. C
			1.00	2.00	-
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111.(
		1.00	2.00	3.00	-
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.	period? s "Y", enter ne	N			112.0
Miscellaneous Cost Reporting Information 5.00[s this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "S for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	B, or E only) 93" percent (includes	N			0115.0
the definition in CMS Pub.15-1, chapter 22, §2208.1. 6.00 Is this facility classified as a referral center? Enter "Y"		N			116. (
"N" for no. 17.00 s this facility legally-required to carry malpractice insur ""V" for you or "N" for no.	rance? Enter	Y			117.0
"Y" for yes or "N" for no. 18.001s the malpractice insurance a claims-made or occurrence pol		2			118. (
if the policy is claim-made. Enter 2 if the policy is occurr	ence.	Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
8.01 List amounts of malpractice premiums and paid losses:		153, 977	(0	0118.
				-	
			1.00	2.00	
Administrative and General? If yes, submit supporting schec and amounts contained therein.					118.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00D0 NOT USE THIS LINE 0.00Is 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 Hold Harmless provision in ACA §3121 and applicable amendment	dule listing d Harmless pr n column 1, " ualifies for	cost centers ovision in ACA Y" for yes or the Outpatient	1.00		118. 119. 120.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 0.00D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter ir "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins	cost centers ovision in ACA Y" for yes or the Outpatient tructions)	1.00 N	2.00	119.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 2000D0 NOT USE THIS LINE 5.000Is 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 Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	1.00 N N	2.00	119. 120. 121.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 0.00D0 NOT USE THIS LINE 0.00 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 Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1.00 N N	2.00	119. 120.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 2000 DO NOT USE THIS LINE 0.00 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 Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5.00 If this is a Medicare certified kidney transplant center, er	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1.00 N N Y N	2.00	119. 120. 121. 122. 125.
Administrative and General? If yes, submit supporting sched and amounts contained therein. 2000D0 NOT USE THIS LINE 5000Is 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 Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1000Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 200Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2. 7.00If this is a Medicare certified heart transplant center, ent	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent pr yes and "N nter the cert 2. ter the certi	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date	1.00 N N Y N	2.00	119. 120. 121. 122. 125. 126.
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 0.00 D0 NOT USE THIS LINE 0.00 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 Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and column 1 and termination date, if applicable, in column 2 and	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2. ter the certi	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	1.00 N N Y N	2.00	119. 120. 121. 122. 125. 126. 127.
 Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 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 Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 8.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 8.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2.	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	1.00 N N Y N	2.00	119. 120. 121. 122. 125. 126. 127. 128.
 and amounts contained therein. 9.00 D0 NOT USE THIS LINE 0.00 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 que Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pr h column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N hter the cert 2. ter the cert 2. ter the cert 2. ter the cert 2. ter the cert 2. ter the cert 3.	cost centers ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date fication date in	1.00 N N Y N	2.00	119. 120. 121. 122.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0001 Period: From 01/01/2019 To 12/31/2019 Worksheet S-2 Part I Date/Time Prep 8/27/2020 4:01 Image: Complex Comp	ared:
	nm
1.00 2.00	pin
in column 1 and termination date, if applicable, in column 2.	32.00
134.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1	33.00 34.00
and termination date, if applicable, in column 2. All Providers	
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, N N 1 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) N 1	40.00
1.00 2.00 3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	
	41.00
	42.00 43.00
1.00 144.00 Are provider based physicians' costs included in Worksheet A? Y	44.00
1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 1	45.00
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	43.00
	46.00
1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 1	47.00
	48.00 49.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 1 Part A Part B Title V Title XIX	49.00
1.00 2.00 3.00 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)	
155.00 Hospital N N N N 1	55.00
	56.00 57.00
158. 00 SUBPROVI DER 1	58.00
	59.00 60.00
	61.00
1.00	
Multicampus	
	65.00
Name County State Zip Code CBSA FTE/Campus	
0 1.00 2.00 3.00 4.00 5.00	((00
166.00 If line 165 is yes, for each 0.001 campus enter the name in column 0, county in column 1, state in 0	66.00
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 1.00	
167.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. Y 1	67.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	68.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship	68.01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 9.991	69.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		Period: From 01/01/2019		
			To 12/31/2019	Date/Time Pre 8/27/2020 4:0	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	nning date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provide			N	C	171.00
section 1876 Medicare cost plans repo					
"Y" for yes and "N" for no in column		nter the number of sectio	'n		
1876 Medicare days in column 2. (see	instructions)				

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Date/Time Pro 8/27/2020 4:0	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO r	esponses. En	1.00 ter all dates in	2.00 the	
	mm/dd/yyyy format. 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			N		1.00
	reporting period? If yes, enter the date of the change in c	Jor unin 2. (See	Y/N	Date	V/I	
			1.00	2.00	3.00	
	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 3, "V" for	N			2.00
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	N			3. 00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	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.	for Compiled,	Y	A		4.00
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit rec		N			5.00
				Y/N 1.00	Legal Oper. 2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lfyes, is t	he provider i	is N		6.00
. 00 . 00	the legal operator of the program? 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		7.00 8.00
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		cal educatio	n N		9.00
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.		the current	Ν		10.00
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	Ν		11.00
					Y/N 1.00	
	Bad Debts		+!		Y	10.00
	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.			cost reporting	Ň	12.00
4.00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	nstructions.	N	14.00
5.00	Did total beds available change from the prior cost reporti		yes, see ins t A		N t B	15.00
	-	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 date of the PS&R Report used in columns 2 and 4 .(see	Y	08/18/2020) Y	08/18/2020	16.00
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Ν		N		17.00
8. 00	in columns 2 and 4. (see instructions) 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	Ν		Ν		18.00
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		19.00

near th	Financial Systems JOHNSON MEMORI	AL_HOSPITAL		In Lie	u of Form CM	<u>S-2552-10</u>
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0001	Period: From 01/01/2019 To 12/31/2019		repared:
			iption	Y/N	Y/N	
20.00	If Line 1/ or 17 is yes were adjustments made to DCOD		0	1.00 N	3.00 N	20.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)			_
22.00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	Instructions				22.00
	Have changes occurred in the Medicare depreciation expense			ring the cost		22.00
20.00	reporting period? If yes, see instructions.			ing the cost		20.00
24.00	Were new leases and/or amendments to existing leases entere	ed into during	this cost r	eporting period?		24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repo	rting period	2 If yes see		25.00
20.00	instructions.	the cost repu	i ting period	. ii yes, see		23.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost report	ing period?	lfyes, see		26.00
27.00	instructions. Has the provider's capitalization policy changed during the	cost reporti	na nori od2 l	f.voc cubmit		27.00
27.00	copy.		ng periou? i	i yes, subiii t		27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit en	ntered into du	ring the cos	t reporting		28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (D	oht Sorvico	Reserve Fund)		29.00
27.00	treated as a funded depreciation account? If yes, see instr		ebt Service	Reserve runu)		27.00
30.00	Has existing debt been replaced prior to its scheduled matu		debt? If ye	s, see		30.00
21 00	instructions.	outpage of now	dab+2 lf va			21 00
31.00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? IT ye	s, see		31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care ser		ed through c	ontractual		32.00
33.00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app		na to compet	itive hidding? If		33.00
00.00	no, see instructions.		ing to compet	rerve braaring. Ti		00.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an ar	rangement wit	h provider-b	ased physi ci ans?		34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreeme	nts with the	provider-based		35.00
	physicians during the cost reporting period? If yes, see in			p		
				Y/N	Date	
	Home Office Costs			1.00	2.00	_
36.00	Were home office costs claimed on the cost report?					36.00
	If line 36 is yes, has a home office cost statement been pr	repared by the	home office	?		37.00
20 00	If yes, see instructions.	fico di fforont	from that a	f		20 00
30. UU	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end					38.00
39 00	If line 36 is yes, did the provider render services to othe			s,		39.00
57.00	see instructions.	home off	lf vo-			40.00
	If I as 0/ is used with the many intervention second and the the	nome office?	TT yes, see			40.00
	If line 36 is yes, did the provider render services to the instructions					
	If line 36 is yes, did the provider render services to the instructions.					
	instructions.		00	2.	00	
40.00	instructions.	1.	00		00	41.00
40.00	instructions.		00	2.	00	41.00
40.00	instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	1. Ti na	00		00	
40.00	instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	1.	00		00	41.00
40. 00 41. 00 42. 00	instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	1. Ti na	00			

Health Financial Systems JOHNSON ME	MORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0001	Peri od:	Worksheet S-2	
		From 01/01/2019 To 12/31/2019	Part II Date/Time Pre 8/27/2020 4:0	pared: <u>1 pm</u>
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	MANAGER			41.00
held by the cost report preparer in columns 1, 2, and 3	1			
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cos	t			43.00
report preparer in columns 1 and 2, respectively.				

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JOHNSON MEMORI	Provi der C	°N· 15_0001	Period:	u of Form CMS-2 Worksheet S-3	
1103F11	AL AND HOSFITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	FIOVICEI C	GN. 15-0001	From 01/01/2019		
					To 12/31/2019		
						8/27/2020 4:0	I pm
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	43	15, 69	95 0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)						2 00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider						2.00
3.00 4.00	HMO IRF Subprovider						4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed SN Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		43	15, 69	0.00		7.00
	beds) (see instructions)		10				
8.00	INTENSIVE CARE UNIT	31.00	6	2, 19	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT			1			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		49	17,88	35 0.00		14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	41.00	0		0		16.00
17.00	SUBPROVIDER - IRF	41.00	0		0	0	17.00 18.00
18.00 19.00	SUBPROVIDER SKILLED NURSING FACILITY						18.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00					23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	СМНС – СМНС						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		49				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		-				31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days						33.00
	3						33.00
	LTCH site neutral days and discharges						

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		Period: From 01/01/2019	Worksheet S-3 Part I	
					To 12/31/2019	Date/Time Pre 8/27/2020 4:0	
		L/P Davs	/ O/P Visits	/ Trips	Full Time F	Equi val ents	<u>I</u>
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Patients	& Residents	Payrol I	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 122	134	5, 29	5		1.
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)	721	1, 314				2.
. 00	HMO I PF Subprovi der	0	1, 314				3.
. 00	HMO I RF Subprovi der	0	0				4.
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		b		5.
. 00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF	0	0		5		6.
. 00	Total Adults and Peds. (exclude observation	2, 122	134		-		7.
. 00	beds) (see instructions)	2, 122	134	5,27			''
.00	INTENSIVE CARE UNIT	241	0	50	3		8.
00	CORONARY CARE UNIT		0				9.
). 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY		42	73	6		13
1.00	Total (see instructions)	2, 363	176	6, 53	5 0.00	555.54	14.
5.00	CAH visits	0	0		C		15
5.00	SUBPROVIDER - IPF						16
. 00	SUBPROVIDER - IRF	0	0		0.00	0.00	17
3. 00	SUBPROVI DER						18
9.00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
. 00	HOME HEALTH AGENCY	2, 793	0	5,00	3 0.00	8. 28	22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE						24
. 10	HOSPICE (non-distinct part)			5	C		24
. 00	CMHC - CMHC						25
5.00	RURAL HEALTH CLINIC						26
b. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
. 00	Total (sum of lines 14-26)		-		0.00	563.82	
. 00	Observation Bed Days		0	88	5		28
. 00	Ambul ance Trips	0					29
. 00	Employee discount days (see instruction)				D D		30
. 00	Employee discount days - IRF		10		2		31
2.00	Labor & delivery days (see instructions)	0	42				32
2. 01	Total ancillary labor & delivery room				C		32
00	outpatient days (see instructions)	o					22
3.00	LTCH non-covered days LTCH site neutral days and discharges	0					33

HOSPI T	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	JOHNSON MEMORIAL AL DATA	Provi der C	CN: 15-0001	Period: From 01/01/2019	u of Form CMS-2 Worksheet S-3 Part I	
					To 12/31/2019		
		Full Time Equivalents	Di s		charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Patients	
1.00	Userital Adulta & Dada (aslumna E. (. 7 and	11.00	12.00	13.00	14.00 33 49	15.00	1.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		0	00	53 49	2, 011	1.00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			10	90 362		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						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	0.00	0		10	2 011	13.00 14.00
14.00 15.00	Total (see instructions) CAH visits	0.00	0	68	33 49	2, 011	14.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0		0 0	0	17.00
18.00	SUBPROVI DER	0.00	0		0	Ū	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00 30.00	Ambulance Trips Employee discount days (see instruction)						29.00 30.00
30.00	Employee discount days (see fistruction) Employee discount days - IRF						30.00
32.00	Labor & delivery days (see instructions)						32.00
32.00	Total ancillary labor & delivery room						32.00
52.01	outpatient days (see instructions)						52.01
33.00	LTCH non-covered days				0		33.00
	LTCH site neutral days and discharges				0		33.01

SPI T	AL WAGE INDEX INFORMATION			Provider C		eriod: rom 01/01/2019	Worksheet S-3 Part II	
					Ť		Date/Time Pre 8/27/2020 4:0	par
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see	200.00	42,012,440	-131, 929	41, 880, 511	1, 172, 754. 00	35. 71	1 1
0	instructions) Non-physician anesthetist Part		0	o	0	0.00	0.00	2
00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3
	В							
00	Physician-Part A - Administrative		0	0	0	0.00	0.00	
)1)0	Physicians - Part A - Teaching Physician and Non		0 1, 295, 853			0. 00 13, 250. 00	0.00 97.80	
0	Physician-Part B		1, 295, 655		1, 295, 655	13, 250. 00	97.00	
00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6
0	Interns & residents (in an	21.00	0	0	0	0.00	0.00	7
01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7
00	programs) Home office and/or related organization personnel		617, 591	0	617, 591	17, 931. 00	34.44	8
00 00	SNF Excluded area salaries (see	44.00	0 13, 195, 226	0 -31, 171	-	0. 00 223, 030. 00	0. 00 59. 02	
00	i nstructi ons) OTHER WAGES & RELATED COSTS		13, 193, 220	-31, 171	13, 104, 055	223, 030. 00	57.02	
00	Contract Labor: Direct Patient		1, 900, 678	0	1, 900, 678	24, 261. 00	78.34	11
00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12
	management and other management and administrative services							
00	Contract Labor: Physician-Part		199, 000	0	199, 000	951.00	209. 25	13
00	A - Administrative Home office and/or related organization salaries and		0	0	0	0.00	0.00	14
01	wage-related costs 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	
00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16
01	Home office Physicians Part A		0	0	0	0.00	0.00	16
02	- Teaching Home office contract Physicians Part A - Teaching		C	0	0	0.00	0.00	16
00	WAGE-RELATED COSTS Wage-related costs (core) (see		7, 623, 467	0	7, 623, 467			1 17
	instructions) Wage-related costs (other) (see instructions)		1, 020, 401		,, 525, 407			18
00	Excluded areas		2, 454, 901	0	2, 454, 901			19
00	Non-physician anesthetist Part A		0	0	0			20
00	Non-physician anesthetist Part B		0	0	0			2
υU	Physician Part A - Administrative		0	0	0			22
01	Physician Part A - Teaching Physician Part B		162 049	0	162 049			22
00 00	Physician Part B Wage-related costs (RHC/FQHC)		163, 068 0	0	163, 068 0			23
00	Interns & residents (in an approved program)		0	0	0			25
50	Home office wage-related		0	0	о			25
51	(core) Related organization		0	0	0			25
52	wage-related (core) Home office: Physician Part A		0		 ∩			25
52	- Administrative - wage-related (core)		0	l				23

Heal th	Financial Systems		JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col		(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	3, 301, 548			8 154, 667. 00	21.35	
27.00	Administrative & General	5.00	2, 256, 321	-69, 587	2, 186, 73	58, 311. 00	37.50	27.00
28.00	Administrative & General under	-	660, 564	0	660, 56	5, 392. 00	122. 51	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	660, 564		660, 56			
31.00	Laundry & Linen Service	8.00	100, 817	0	100, 81			31.00
32.00	Housekeepi ng	9.00	641, 899	0	641, 89	46, 451. 00	13. 82	32.00
33.00	Housekeeping under contract		0	0)	0 0.00	0.00	33.00
	(see instructions)							
34.00	Dietary	10.00	730, 352	-489, 681	240, 67	14, 238. 00	16. 90	34.00
35.00	Dietary under contract (see		0	0		0 0.00	0.00	35.00
	instructions)							
36.00	Cafeteria	11.00	0	489, 681	489, 68			36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00		
38.00	Nursing Administration	13.00	1, 239, 863	0	1, 239, 86	23, 061. 00	53.76	38.00
39.00	Central Services and Supply	14.00	76, 893	0	76, 89	4, 396. 00	17.49	39.00
40.00	Pharmacy	15.00	564, 052	0	564, 05	14, 685. 00	38. 41	40.00
41.00	Medical Records & Medical	16.00	490, 739	0	490, 73	24, 244. 00	20. 24	41.00
	Records Library							
42.00	Soci al Servi ce	17.00	0	0		0 0.00		42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

Heal th	Financial Systems		JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		40, 759, 560	-131, 929	40, 627, 63	1 1, 146, 965. 00	35.42	1.00
	instructions)							
2.00	Excluded area salaries (see		13, 195, 226	-31, 171	13, 164, 05	5 223, 030. 00	59.02	2.00
	instructions)							
3.00	Subtotal salaries (line 1		27, 564, 334	-100, 758	27, 463, 57	6 923, 935. 00	29.72	3.00
	minus line 2)							
4.00	Subtotal other wages & related		2,099,678	0	2, 099, 67	8 25, 212. 00	83.28	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		7, 623, 467	0	7, 623, 46	7 0.00	27.76	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		37, 287, 479	-100, 758	37, 186, 72	1 949, 147. 00	39. 18	6.00
7.00	Total overhead cost (see		10, 723, 612	-69, 587	10, 654, 02	5 412, 445. 00	25.83	7.00
	instructions)							
				1	1	1 1		1

Heal th	Financial Systems JOHN	ISON MEMORIAL HOSPITA	AL.		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL WAGE RELATED COSTS	Provi de	er CCN:	15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part IV Date/Time Pre 8/27/2020 4:0	pared:
						Amount	
						Reported 1.00	
	PART IV - WAGE RELATED COSTS					1.00	
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					934, 063	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	,04,000	2.00				
3.00	Nonqualified Defined Benefit Plan Cost (see instr		0	3.00			
4.00	Qualified Defined Benefit Plan Cost (see instruct		0	4.00			
	PLAN ADMINISTRATIVE COSTS (Paid to External Organ					<u> </u>	
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan					0	6.00
7.00	Employee Managed Care Program Administration Fees	5				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					0	8.00
8.01	Health Insurance (Self Funded without a Third Par	ty Administrator)				0	8.01
8.02	Health Insurance (Self Funded with a Third Party	Administrator)				6, 135, 927	8.02
8.03	Heal th Insurance (Purchased)					0	8.03
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					0	10.00
11.00	Life Insurance (If employee is owner or beneficia	iry)				26, 143	11.00
12.00	Accident Insurance (If employee is owner or benef	ficiary)				0	12.00
13.00	Disability Insurance (If employee is owner or ber					167, 621	13.00
	Long-Term Care Insurance (If employee is owner or	benefi ci ary)				0	14.00
15.00	'Workers' Compensation Insurance					234, 668	15.00
16.00	Retirement Health Care Cost (Only current year, r	not the extraordinary	y accru	ial requir	ed by FASB 106.	0	16.00
	Non cumulative portion)						
	TAXES						
	FICA-Employers Portion Only					2, 695, 776	
18.00	Medicare Taxes - Employers Portion Only					0	18.00
19.00						18, 326	
20.00	State or Federal Unemployment Taxes					0	20.00
21 00	OTHER	and the second s			unda da ala sua da a	0	21 00
21.00	Executive Deferred Compensation (Other Than Retir instructions))	ement Cost Reported	on IIr	ies i thro	ugn 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00						28, 912	
24.00	Total Wage Related cost (Sum of lines 1 -23)					10, 241, 436	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00

Heal th	Financial Systems	JOHNSON MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-00	F	eriod: rom 01/01/2019 o 12/31/2019		
				I	o 12/31/2019	Date/Time Pre 8/27/2020 4:0	
	Cost Center Description				Contract	Benefit Cost	
					Labor 1.00	2.00	
	PART V - Contract Labor and Benefit Cost				1.00	2.00	
	Hospital and Hospital-Based Component Identi	fication:					
1.00	Total facility's contract labor and benefit	cost			1, 900, 678	10, 241, 436	1.00
2.00	Hospi tal				1, 900, 678	10, 241, 436	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	Hospital-Based Hospice						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
17.00	Renal Dialysis						17.00
18.00	Other				0	0	18.00

Heal th	Financial Systems	JOHNSON MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
HOME H	IEALTH AGENCY STATI STI CAL DATA		Provider C		Period: From 01/01/2019		
			Component	CCN: 15-7510	To 12/31/2019	8/27/2020 4:0	
					Home Health Agency I	PPS	
					1	00	
0.00	County						0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	0		0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)		132.00	0. (0.00	0.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the number		Staff	Contract	Total	
		your normal	work week				
		0		1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	1.	53 0.00	1.53	3.00
4.00 5.00	Director(s) and Assistant Director(s) Other Administrative Personnel			0.			•
6. 00	Direct Nursing Service			2.4			•
7.00 8.00	Nursing Supervisor Physical Therapy Service			0.0			•
9.00	Physical Therapy Supervisor			0.0	0. 00	0.00	9.00
10.00 11.00	Occupational Therapy Service Occupational Therapy Supervisor			0.0			•
12.00	Speech Pathology Service			0.0	0. 00	0.00	12.00
13.00 14.00	Speech Pathology Supervisor Medical Social Service			0.0			
15.00	Medical Social Service Supervisor			0.0	0. 00	0.00	15.00
16.00 17.00	Home Health Aide Home Health Aide Supervisor			0.			
18.00	Other (specify)			0.0			•
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost						
20.00	reporting period. List those CBSA code(s) in column 1 serviced	1		18020			20.00
	during this cost reporting period (line 20 contains the first code).						
20. 01				26900			20.01
		Full Epi Without W		LUPA Epi sode	s PEP Only	Total (cols.	
		0utliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5.00	
	PPS ACTIVITY DATA			1		1	
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	1, 315 315, 600	0	5, 7	24 27 50 6,480		1
23.00	Physical Therapy Visits	802	0		0 27	829	23.00
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	207, 480 577	0		0 7,020 0 21	214, 500 598	
26.00	Occupational Therapy Visit Charges	150, 020	0		0 5,460	155, 480	26.00
27.00 28.00	Speech Pathology Visits Speech Pathology Visit Charges	0 1, 040	0		0 0	0 1,040	
29.00	Medical Social Service Visits	0	0		0 0	0	•
30.00 31.00	Medical Social Service Visit Charges Home Health Aide Visits	0	0		0 0	0	
32.00 33.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	0 2, 694	0		0 0 24 75	0 2, 793	
	29, and 31)	2,074	U				
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 674, 140	0	5, 7	0 0 50 18,960	0 698, 860	
	30, 32, and 34)		0				
36.00	Total Number of Episodes (standard/non outlier)	157			11 5	173	
37.00 38.00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	9, 207	0 0	1	0 50 1, 449	0 10, 816	37.00 38.00

Heal th	Financial Systems JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0001	Peri od:	Worksheet S-1	0
				From 01/01/2019 To 12/31/2019	Date/Time Pre 8/27/2020 4:0	pared: 1 pm
					1 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 c	hivided by Li	ine 202 colum	n 8)	0. 249953	1.00
1.00	Medicaid (see instructions for each line)				0.217700	1.00
2.00	Net revenue from Medicaid				1, 920, 106	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme	ental pavmen [.]	ts from Medic	ai d?	Ý	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments				0	5.00
6.00	Medicaid charges				32, 826, 549	6.00
7.00	Medicaid cost (line 1 times line 6)				8, 205, 094	7.00
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	n (line 7 min	nus sum of li	nes 2 and 5; if	6, 284, 988	8.00
	Children's Health Insurance Program (CHIP) (see instructions	for each lir	ne)			
9.00	Net revenue from stand-alone CHIP		,		0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIF	o (line 11 mi	inus line 9;	if < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see in					
	Net revenue from state or local indigent care program (Not ir				0	
14.00	Charges for patients covered under state or local indigent ca	are program	(Not included	in lines 6 or	0	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line				0	
16.00	Difference between net revenue and costs for state or local i	ndigent care	e program (li	ne 15 minus line	0	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, C	HIP and stat	te/local indi	gent care progra	IMS (SEE	
	instructions for each line)		to, roour mar	gone our o progre		
17.00	Private grants, donations, or endowment income restricted to	fundi ng chai	rity care		0	17.00
18.00	Government grants, appropriations or transfers for support of	[∼] hospital o	perations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loc	al indigent	care program	s (sum of lines	6, 284, 988	19.00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	0.00	
20.00	Charity care charges and uninsured discounts for the entire f	Facility	3, 253, 44	40 3, 579, 253	6, 832, 693	20.00
	(see instructions)	- J				
21.00	Cost of patients approved for charity care and uninsured disc	counts (see	813, 20	3, 579, 253	4, 392, 460	21.00
	instructions)	-	ĺ			
22.00	Payments received from patients for amounts previously writte	en off as		0 0	0	22.00
	charity care					
23.00	Cost of charity care (line 21 minus line 22)		813, 20	3, 579, 253	4, 392, 460	23.00
					1.00	
24.00	Deep the amount on Line 20 column 2 include charges for noti	ant dava ha	uand a langth	of stay limit	1.00 N	24.00
24.00	Does the amount on line 20 column 2, include charges for pati imposed on patients covered by Medicaid or other indigent car		yond a rength	or stay rimit	IN	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond		t care progra	m's length of	0	25.00
26 00	stay limit	netructione	\ \		1 610 672	26.00
26.00 27.00	Total bad debt expense for the entire hospital complex (see i Medicare reimbursable bad debts for the entire hospital compl				4, 648, 623 79, 049	
		•				
	Medicare allowable bad debts for the entire hospital complex	(see instruc	crons)		121,614	1
28.00	Non-Medicare bad debt expense (see instructions)	whomas (I not not the second	`	4, 527, 009	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	expense (see	Instructions)	1, 174, 104	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1100 20)			5, 566, 564	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	rine 30)			11, 851, 552	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JOHNSON MEMORIA OF EXPENSES	Provider C		eriod:	u of Form CMS-2 Worksheet A	2002-10
				FI	rom 01/01/2019 0 12/31/2019	Date/Time Pre 8/27/2020 4:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		200.070	200 070		200.070	1 1 00
1.00 2.00	00200 CAP REL COSTS-BEDG & FIXT		300, 970 4, 413, 837	300, 970 4, 413, 837	0	300, 970 4, 413, 837	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	320, 524	7, 971, 473		69, 587	8, 361, 584	•
4.01	00401 COMMUNI CATI ONS	87, 923	275, 726		-55	363, 594	4.01
4.02	00402 DATA PROCESSING	770, 890	2, 237, 254		-13	3,008,131	4.02
4.03 4.04	00403 MATERI ALS MANAGEMENT 00404 ADMI TTI NG	336, 396 773, 909	35, 835 6, 664	372, 231 780, 573	-2, 161 -344	370, 070 780, 229	4.03
4.05	00405 PATIENT ACCOUNTING	1,011,906	722, 495	1, 734, 401	0	1, 734, 401	4.05
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 256, 321	6, 087, 513	8, 343, 834	-70, 283	8, 273, 551	5.00
7.00	00700 OPERATION OF PLANT	660, 564	2,043,903		-133	2,704,334	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	100, 817 641, 899	90, 540 102, 242	191, 357 744, 141	-890 -7, 936	190, 467 736, 205	
10.00	01000 DI ETARY	730, 352	354, 316	1, 084, 668	-727, 395	357, 273	
11.00	01100 CAFETERI A	0	0	0	727, 240	727, 240	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 239, 863	198,008	1, 437, 871	-325	1, 437, 546	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	76, 893 564, 052	129, 700 5, 028, 592	206, 593 5, 592, 644	-51, 329 -4, 110, 769	155, 264 1, 481, 875	
16.00	01600 MEDICAL RECORDS & LIBRARY	490, 739	70, 368		-51	561, 056	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	4, 406, 949 1, 119, 267	821, 483 347, 294	5, 228, 432 1, 466, 561	-579, 587 -42, 303	4, 648, 845 1, 424, 258	
41.00	04100 SUBPROVI DER – I RF	1, 119, 207	347, 294	1, 400, 501	-42, 303	1, 424, 258	
43.00	04300 NURSERY	0	0	0	424, 963	424, 963	
	ANCI LLARY SERVICE COST CENTERS	1 00 (507	504.050	0 440 055	000 544		
50.00 53.00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	1, 886, 597 0	524, 258 12, 180	2, 410, 855 12, 180	-288, 514 54, 961	2, 122, 341 67, 141	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 997, 127	1, 133, 048		-93, 370	3, 036, 805	•
60.00	06000 LABORATORY	1, 941, 363	2, 524, 572	4, 465, 935	-200, 067	4, 265, 868	
65.00	06500 RESPI RATORY THERAPY	1,039,211	208, 360	1, 247, 571	-58, 991	1, 188, 580	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	743, 133 266, 810	29, 594 0	772, 727 266, 810	-16, 392 0	756, 335 266, 810	
68.00	06800 SPEECH PATHOLOGY	138, 624	62	138, 686	0	138, 686	•
69.00	06900 ELECTROCARDI OLOGY	294, 100	99, 319	393, 419	-6, 873	386, 546	
70.00	07000 ELECTROENCEPHALOGRAPHY	6, 682	6, 333	13, 015	-259	12, 756	•
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 894, 053 0	3, 894, 053 0	-1, 195, 167 2, 690, 246	2, 698, 886 2, 690, 246	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	4, 626, 457	4, 626, 457	
76.00	03020 ONCOLOGY	304, 831	196, 484	501, 315	-8, 657	492, 658	
76.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	135, 499	167, 552	303, 051	-5, 445	297, 606	76.97
90.00	09000 CLINIC	699, 565	2,030,806	2, 730, 371	-460, 901	2, 269, 470	90.00
91.00	09100 EMERGENCY	3, 774, 408	970, 546		-71, 831	4, 673, 123	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	620, 608	112, 928	733, 536	-11, 490	722, 046	101 00
101.00	SPECIAL PURPOSE COST CENTERS	020,000	112, 720	, 00, 000	11, 170	722,010	
	11300 INTEREST EXPENSE		0		0		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	29, 437, 822	43, 148, 445	72, 586, 267	581, 923	73, 168, 190	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	50, 611	28, 960	79, 571	-167	79, 404	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	12, 374, 268	4, 128, 341		-576, 256	15, 926, 353	
	19201 SOUTH CLINIC	0	0	0	0		192.01
	19202 WEST CLINIC 19203 DIABETES CENTER	0 73, 794	0 6 172	0 79, 967	0 -5, 500		192.02
	19203 DIABETES CENTER 19300 NONPALD WORKERS	13, 194	6, 173 0	, 96, 79, 0	-5, 500		192.03 193.00
193.0	19301 ADULT/CHI LD CARE	1, 836	141	1, 977	Ö	1, 977	193.01
	19302 PHYSI CI AN OFFI CE BUI LDI NG	0	0	0	0		193.02
	19303 OPTI FAST/FOUNDATI ON	0	47 014	0	0		193.03 194.00
	07950 PARTNERSHI P HFC 07951 TRAFALGAR CLI NI C	26, 109 0	47, 016 0	73, 125 0	0		194.00
194.02	07952 EDI NBURGH	0	0	0	0	0	194.02
194.03	07953 JAI L	48, 000	0	48,000	0	48,000	194.03
194. 04 200. 00	O7954 ATHLETIC TRAINERS TOTAL (SUM OF LINES 118 through 199)	0	47 250 076	00 271 514	0	0 89, 371, 516	194.04
∠UU. U	INTAL (SUM OF LINES IN UNIOUGH 199)	42,012,440	47, 359, 076	89, 371, 516	U	07, 3/1, 310	I∠00.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	JOHNSON MEMORI	AL HOSPITAL Provider CC	N: 15-0001	Period:	J of Form CMS- Worksheet A	-2552-1(
(LOLASS	ATTORTION AND ADJOITMENTS OF TREAL DREAMOR O			N. 13 0001	From 01/01/2019 To 12/31/2019	Date/Time Pro	epared:
	Cost Center Description	Adjustments	Net Expenses			8/27/2020 4:	01 pm
	cost center bescription	(See A-8)	For				
			Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS	2 052 (22	2 552 ((2				1 1 00
-	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	-3, 853, 632 0	-3, 552, 662 4, 413, 837				1.00
	DO400 EMPLOYEE BENEFITS DEPARTMENT	-85, 304	8, 276, 280				4.00
	DO401 COMMUNI CATI ONS	-21, 347	342, 247				4.01
	DO402 DATA PROCESSI NG	0	3, 008, 131				4.02
1	DO4O3 MATERIALS MANAGEMENT	0	370, 070				4.03
	DO404 ADMI TTI NG	0	780, 229				4.04
		-162	1,734,239				4.05
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-446, 391 -36, 731	7, 827, 160 2, 667, 603				5.00
	DO800 LAUNDRY & LINEN SERVICE	-30, 731	190, 467				8.00
	DO900 HOUSEKEEPI NG	0	736, 205				9.00
	D1000 DI ETARY	0	357, 273				10.00
1.00	01100 CAFETERI A	-308, 993	418, 247				11.00
1	D1300 NURSI NG ADMI NI STRATI ON	-9	1, 437, 537				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	155, 264				14.00
		-28	1, 481, 847				15.00
-	01600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	-37, 727	523, 329				16.00
	D3000 ADULTS & PEDIATRICS	-1, 736, 797	2, 912, 048				30.00
	D3100 I NTENSI VE CARE UNI T	-252, 385	1, 171, 873				31.00
	04100 SUBPROVI DER – I RF	0	137				41.00
3.00	D4300 NURSERY	0	424, 963				43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	2, 122, 341				50.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	67, 141 3, 036, 805				53.00 54.00
	D6000 LABORATORY	-5, 098	4, 260, 770				60.00
	06500 RESPIRATORY THERAPY	3, 070	1, 188, 580				65.00
	06600 PHYSI CAL THERAPY	-1,059	755, 276				66. OC
7.00	06700 OCCUPATI ONAL THERAPY	0	266, 810				67.00
	D6800 SPEECH PATHOLOGY	0	138, 686				68.00
		-28, 953	357, 593				69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 756 2, 698, 886				70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 690, 246				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	4, 626, 457				73.00
	D3020 ONCOLOGY	-105, 414	387, 244				76. OC
	07697 CARDI AC REHABI LI TATI ON	-41, 500	256, 106				76.97
-	DUTPATIENT SERVICE COST CENTERS						_
	09000 CLINIC	-600, 079					90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-2, 528, 704	2, 144, 419				91.00 92.00
	OTHER REIMBURSABLE COST CENTERS						92.00
	10100 HOME HEALTH AGENCY	0	722, 046				101.00
\$	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	0	0				113.00
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	-10, 090, 313	63,077,877				118.00
	NONREIMBURSABLE COST CENTERS	0	70 404				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	79, 404 15, 926, 353				190.00 192.00
	19200 SOUTH CLINIC	0	15, 720, 555				192.00
	19202 WEST CLINIC	0	0				192.02
	19203 DI ABETES CENTER	0	74, 467				192.03
	19300 NONPALD WORKERS	0	0				193.00
	19301 ADULT/CHI LD CARE	0	1, 977				193. Oʻ
	19302 PHYSI CI AN OFFI CE BUI LDI NG	0	0				193.02
	19303 OPTI FAST/FOUNDATI ON	0	72 125				193.03
	07950 PARTNERSHI PHFC 07951 TRAFALGARCLI NI C	0	73, 125 0				194.00 194.01
	07951 TRAFALGAR CLINIC 07952 EDI NBURGH	0	0				194.01
	07953 JAI L	0	48,000				194.02
	07954 ATHLETIC TRAINERS	0	0				194.04
	TOTAL (SUM OF LINES 118 through 199)	-10,090,313	79, 281, 203				200.00

	Financial Systems IFICATIONS		JOHNSON MEMORI A	AL HOSPITAL Provider CCN: 15-	-0001 Period: Work From 01/01/2019 To 12/31/2019 Date	Form CMS-2552-1 sheet A-6 e/Time Prepared:
		Increases				/2020 4:01 pm
	Cost Center	Line #	Salary	Other		
	2.00 A - NURSERY RECLASS	3.00	4.00	5.00		
	NURSERY	43.00	<u>390, 2</u> 45	3 <u>4, 7</u> 18		1.00
			390, 245	34, 718		
	B - IMPLANTABLE RECLASS	72.00	0	2, 690, 246		1.00
	PATI ENT					
	TOTALS C - CAFETERIA RECLASS		0	2, 690, 246		
		11.00	489, 681	237, 559		1.00
	TOTALS		489, 681	237, 559		
	D - STD RECLASS RADI OLOGY-DI AGNOSTI C	54.00	0	31, 171		1.00
0	HOME HEALTH AGENCY	101.00	0	6, 415		2.00
	PHYSICIANS' PRIVATE OFFICES	192.00	0	19, 500		3.00
0	PARTNERSHI P_HFC	<u>194.00</u>	0	<u>5, 256</u> 62, 342		4.00
	E - EMPLOYEE WELLNESS RECLASS	L.				
0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	<u>69, 5</u> 87 69, 587		1.00
	F - PART A RECLASS		U	07, 007		
0	ADULTS & PEDIATRICS	30.00	0	5, 500		1.00
0	ANESTHESI OLOGY	<u>53.00</u>	0	5 <u>5,000</u> 60,500		2.00
	G - MEDICIAL SUPPLIES RECLASS		<u> </u>			
	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 495, 079		1.00
0	PATIENTS	0.00	0	о		2.00
5		0.00	Ö	Ö		3.00
0		0.00	0	0		4.00
))		0.00 0.00	0	0		5.00
5		0.00	0	0		7.0
0		0.00	0	0		8.00
0 00		0.00 0.00	0	0		9.0
00		0.00	0	Ö		11.0
00		0.00	0	0		12.0
00 00		0.00 0.00	0	0		13.0
00		0.00	0	0		15.0
00		0.00	0	0		16.0
00 00		0.00 0.00	0	0		17.0 18.0
00		0.00	0	0		19.0
00 00		0. 00 0. 00	0 0	0		20.0
00		0.00	0	0		21.0
00		0.00	0	0		23.0
00 00		0.00 0.00	0	0		24.0 25.0
00		0.00	0	0		25.0
00		0.00	0	0		27.0
00 00		0. 00 0. 00	0	0		28.0 29.0
00		0.00		0		30.0
			0	1, 495, 079		
	H - DRUGS CHARGEABLE RECLASS DRUGS CHARGED TO PATIENTS	73.00	0	4, 626, 457		1.0
0		0.00	0	0		2.0
0 0		0. 00 0. 00	0	0		3.0
5		0.00	0	0		4.0 5.0
C		0.00	О	0		6.0
C C		0. 00 0. 00	0	0		7.0
))		0.00	0	0		8.0
00		0.00	õ	0		10.0
00		0.00	0	0		11.0
00 00		0. 00 0. 00	0	0		12.0
00		0.00	0	0		14.00
	TOTALS			4, 626, 457		1

	SI FI CATI ONS			Provider (CCN: 15-0001	Period: From 01/01/2019	Worksheet A-6
						To 12/31/2019	Date/Time Prepare 8/27/2020 4:01 pm
	Cost Center	Decreases Line #	Salary	Other	Wkst. A-7 Ref	-	
	6.00	7.00	8.00	9.00	10.00	<u>·</u>	
	A - NURSERY RECLASS	7.00	0.00	7.00	10.00		
0	ADULTS & PEDI ATRI CS		390, 245	34, 718		0	1.
			390, 245	34, 718			
0	B - IMPLANTABLE RECLASS MEDICAL SUPPLIES CHARGED TO	71.00	0	2, 690, 246		0	1.
.0	PATI ENTS	, 1. 00		2,0,0,210			
	TOTALS		0	2, 690, 246]	
0	C - CAFETERIA RECLASS	10.00	400 401	227 550	1	0	1
0	DI ETARY	<u>10.00</u>	<u>489, 681</u> 489, 681	<u>237,559</u> 237,559		0	1.
	D - STD RECLASS		107,001	2017007			
0	RADI OLOGY-DI AGNOSTI C	54.00	31, 171	0		0	1.
00	HOME HEALTH AGENCY	101.00	6, 415	0		0	2.
0 0	PHYSICIANS' PRIVATE OFFICES PARTNERSHIP HFC	192.00 194.00	19, 500 5, 256	0 0		0	3.
.0	TOTALS		62, 342	0			
	E - EMPLOYEE WELLNESS RECLASS				T		
0	ADMI NI STRATI VE & GENERAL	5.00	<u> </u>	0		Q	1.
	TOTALS F - PART A RECLASS		69, 587	0			
0	PHYSICIANS' PRIVATE OFFICES	192.00	0	55,000		0	1.
0	DI ABETES CENTER	192.03	0	5, 500		<u>o</u>	2.
	TOTALS		0	60, 500			
0	G - MEDICIAL SUPPLIES RECLASS COMMUNICATIONS	4.01	0	55		0	1.
0	DATA PROCESSING	4.01	0	13		0	2.
0	MATERIALS MANAGEMENT	4.03	0	2, 161		0	3.
0	ADMI TTI NG	4.04	0	344		0	4.
00	ADMI NI STRATI VE & GENERAL	5.00	0	238		0	5.
0 0	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7.00 8.00	0	133 890		0	6.
0	HOUSEKEEPI NG	9.00	0	7, 936		0	8.
0	DI ETARY	10.00	0	155		0	9.
00	NURSING ADMINISTRATION	13.00	0	325		0	10.
00 00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	51, 329 4, 418		0	11.
00	MEDICAL RECORDS & LIBRARY	16.00	0	4, 418		0	13.
00	ADULTS & PEDIATRICS	30.00	0	158, 347		0	14.
00	INTENSIVE CARE UNIT	31.00	0	41, 298		0	15.
00	OPERATI NG ROOM ANESTHESI OLOGY	50.00	0	288, 323		0	16.
00 00	RADI OLOGY – DI AGNOSTI C	53.00 54.00	0	39 86, 230		0	17.
00	LABORATORY	60.00	0	200, 018		0	19.
00	RESPI RATORY THERAPY	65.00	0	44, 635		0	20.
00	PHYSICAL THERAPY	66.00	0	16, 283		0	21.
00 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69.00 70.00	0	6, 856 259		0	22.
00	ONCOLOGY	76.00	o	7, 261		0	23
00	CARDIAC REHABILITATION	76. 97	0	5, 445		0	25
00		90.00	0	379, 359		0	26
00	EMERGENCY HOME HEALTH AGENCY	91.00 101.00	0	70, 869 11, 490		0	27.
00 00	GIFT, FLOWER, COFFEE SHOP &	101.00 190.00	0	11, 490		0	28.
	CANTEEN	1,0.00	ĭ	107		-	27.
00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	<u>o</u>	11 <u>0, 1</u> 52		Q	30.
	TOTALS H - DRUGS CHARGEABLE RECLASS		0	1, 495, 079			
0	ADMI NI STRATI VE & GENERAL	5.00	0	458		0	1.
0	PHARMACY	15.00	0	4, 106, 351		0	2.
0	ADULTS & PEDIATRICS	30.00	0	1, 777		0	3.
0	INTENSIVE CARE UNIT	31.00	0	1,005		0	4.
0 0	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00		191 7, 140		0	5.
0	LABORATORY	60.00	o	49		ő	7.
0	RESPI RATORY THERAPY	65.00	0	14, 356		0	8.
0	PHYSI CAL THERAPY	66.00	0	109		0	9.
00 00	ELECTROCARDI OLOGY ONCOLOGY	69.00 76.00	0	17 1, 396			10
	CLINIC	90.00	0	81, 542		0	11.
00	EMERGENCY	91.00	Ő	962		0	13.
00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	<u>o</u>	41 <u>1, 104</u>		Q	14.
	TOTALS Grand Total: Decreases		0	4, 626, 457 9, 144, 559			500.

Health Financial Systems	JOHNSON MEMORI				eu of Form CMS-2	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0001	Peri od:	Worksheet A-7	
				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2015	8/27/2020 4:0	1 pm
			Acqui si ti on	IS		
	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 A	SSET BALANCES					
1.00 Land	4, 743, 426	0		0 0	0 0	1 11 00
2.00 Land Improvements	2, 889, 286	0		0 0	8, 467	2.00
3.00 Buildings and Fixtures	0	0		0 0	0 0	3.00
4.00 Building Improvements	69, 624, 719	39, 119		0 39, 119	1, 140, 790	4.00
5.00 Fixed Equipment	13, 061, 221	47, 187		0 47, 187	7 0	5.00
6.00 Movable Equipment	53, 258, 520	1, 347, 231		0 1, 347, 231	I 783, 153	6.00
7.00 HIT designated Assets	0	0		0 (0 0	7.00
8.00 Subtotal (sum of lines 1-7)	143, 577, 172	1, 433, 537		0 1, 433, 537	1, 932, 410	8.00
9.00 Reconciling Items	0	0		0 (0 0	9.00
10.00 Total (line 8 minus line 9)	143, 577, 172	1, 433, 537		0 1, 433, 537	1, 932, 410	10.00
	Endi ng	Ful I y				
	Bal ance	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL A						
1.00 Land	4, 743, 426	0				1.00
2.00 Land Improvements	2, 880, 819	0				2.00
3.00 Buildings and Fixtures	0	0				3.00
4.00 Building Improvements	68, 523, 048	0				4.00
5.00 Fixed Equipment	13, 108, 408	0				5.00
6.00 Movable Equipment	53, 822, 598	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	143, 078, 299	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	143, 078, 299	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		Provi der C	CN: 15-0001	Period:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	pared:
						8/27/2020 4:0	1 pm
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	300, 970)	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 413, 837			0 0	0	2.00
3.00	Total (sum of lines 1-2)	4, 714, 807)	0 0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)	1			
		Capital -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	300, 970				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	4, 413, 837				2.00
3.00	Total (sum of lines 1-2)	0	4, 714, 807	,			3.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part III Date/Time Prep 8/27/2020 4:07	
	COMF	PUTATION OF RAT	LI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	<u>col. 2)</u> 3.00	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	3.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	143, 078, 299	0	143, 078, 29	9 1. 000000	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0. 000000		2.00
3.00 Total (sum of lines 1-2)	143, 078, 299		143, 078, 29			3.00
	ALLOCA	FION OF OTHER (CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relat				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT		0			0	1.00
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	0	0		-3, 552, 662 4, 413, 837		2.00
3.00 Total (sum of lines 1-2)	0	0		0 4, 413, 837 0 861, 175		2.00
	0	U SI	I IMMARY OF CAPI		0	3.00
		50		IAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C 1.00 NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0	0		0	-3, 552, 662	1.00
2.00 CAP REL COSTS-BLDG & FIXT					4, 413, 837	2.00
3.00 Total (sum of lines 1-2)	0	0 0			861, 175	3.00
	. 0		I Y	-		0.00

Heal th	Financial Systems		JOHNSON MEMOR	I AL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provider CCN: 15-0001 F	Period:	Worksheet A-8	
					From 01/01/2019 To 12/31/2019		
				Expense Classification on	Worksheet A	8/27/2020 4:0	I pm
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1. 00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		C	NEW CAP REL COSTS-BLDG &	1.00	0	1.00
2.00	Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		C		0.00	0	3.00
4 00	(chapter 2)				0.00		4 00
4.00	Trade, quantity, and time discounts (chapter 8)		C)	0.00	0	4.00
5.00	Refunds and rebates of		C		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)						
7.00	Telephone services (pay stations excluded) (chapter				0.00	0	7.00
	21)						
8.00	Television and radio service (chapter 21)		C)	0.00	0	8.00
9.00	Parking lot (chapter 21)		C		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5, 294, 891			0	10.00
11.00	Sale of scrap, waste, etc.		C		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	0			0	12.00
	transactions (chapter 10)						
13.00 14.00	Laundry and linen service Cafeteria-employees and guests				0.00 0.00	0	13.00 14.00
15.00	Rental of quarters to employee		0		0.00	0	15.00
16.00	and others Sale of medical and surgical				0.00	0	16.00
10.00	supplies to other than				0.00	0	10.00
17 00	patients Sale of drugs to other than				0.00	0	17.00
17.00	patients				0.00	0	17.00
18.00	Sale of medical records and abstracts		C		0.00	0	18.00
19.00	Nursing and allied health		C		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20.00	Vendi ng machi nes		C		0.00	0	
21.00	Income from imposition of interest, finance or penalty		C		0.00	0	21.00
	charges (chapter 21)						
22.00	Interest expense on Medicare		C		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
	limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		C	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		c	FIXT CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
	COSTS-MVBLE EQUIP						
28.00 29.00	Non-physician Anesthetist Physicians' assistant)*** Cost Center Deleted ***	19.00 0.00	0	28.00 29.00
30.00	Adjustment for occupational	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)		Ι			I	

ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	3
					From 01/01/2019 To 12/31/2019	Date/Time Pre 8/27/2020 4:0	
				Expense Classification or To/From Which the Amount is			
					to be Aujusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.0
	Depreciation and Interest	D	200,002			-	
	CAFETERIA CANTEEN VENDING REVENUE	В		CAFETERI A	11.00	0	
33. 01	CAFETERIA CANTEEN VENDING REVENUE	В	-162	PATIENT ACCOUNTING	4.05	0	33.0
33. 02	CAFETERIA CANTEEN VENDING REVENUE	В	- 339	OPERATION OF PLANT	7.00	0	33.0
	MISC OTHER REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	
	MISC OTHER REVENUE	В		PHARMACY	15.00	0	
	MISC OTHER REVENUE	В		MEDICAL RECORDS & LIBRARY	16.00	0	
	MISC OTHER REVENUE	В			60.00	0	
	CABLE SERVICES	A		OPERATION OF PLANT	7.00	0	
	TELEPHONE SERVI CES	A		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	
33.09	TELEPHONE SERVICES	A		ADMINISTRATIVE & GENERAL	5.00	0	
	COMMUNI CATI ONS	A		COMMUNI CATI ONS	4.01	0	
	ADVERTISING EXP - A&G	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 12	ADVERTISING EXP - NURSING ADMIN	A	-9	NURSING ADMINISTRATION	13.00	0	33.1
33.13	ADVERTISING EXP - LABORATORY	Α	-166	LABORATORY	60.00	0	33.1
33.14	DAYCARE	В	-741	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.1
33. 15	LOBBYING EXPENSE - IHHA	А	-1, 969	ADMINISTRATIVE & GENERAL	5.00	0	33.1
33.16	PROF – BUILDING	А	-23, 407	ADMINISTRATIVE & GENERAL	5.00	0	33.1
33.17	PROF – BUILDING	А	-7, 716	OPERATION OF PLANT	7.00	0	33.1
33. 18	1993 AHA LIFE	А	-84, 563	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.1
33. 19	HAF EXPENSE	А	-3, 852, 455	NEW CAP REL COSTS-BLDG &	1.00	9	33.1
33. 20	INTEREST EXPENSE	А	-4, 357	ADMI NI STRATI VE & GENERAL	5.00	0	33.2
33. 21	LOBBYING EXPENSE-AHA	А	-5, 541	ADMI NI STRATI VE & GENERAL	5.00	0	00.2
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-10, 090, 313				50.00

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.

	Financial Syste		JOHNSON MEMO	RI AL_HOSPI TAL			eu of Form CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period: From 01/01/2019	Worksheet A-8	3-2
						To 12/31/2019		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1, 736, 797	1, 736, 797	C	0	0	1.00
2.00	31.00	INTENSIVE CARE UNIT	252, 385		C	0	0	2.00
3.00	60.00	LABORATORY	137, 925	0	137, 925	211, 500	1, 975	3.00
4.00	66.00	PHYSICAL THERAPY	1,059	1, 059	C	0	0	4.00
5.00	69.00	ELECTROCARDI OLOGY	59,051	0	59, 051	211, 500	296	5.00
6,00		ONCOLOGY	132, 258	0				
7.00		CARDI AC REHABI LI TATI ON	41, 500			0	0	
8.00		CLINIC	600, 079			0	0	8.00
9,00		EMERGENCY	2, 528, 704			0	0	9.00
10.00	0.00		2, 320, 704	2, 320, 704			0	
200.00	0.00		5, 489, 758	5, 160, 524	329, 234		Ŭ	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadj usted RCE		Cost of	Provi der	Physician Cost	
	WK3t. A LITTE π	I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
		rdentifier			Continuing	Share of col.		
					Education	12	Thisui ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0.00					1.00
2.00		I NTENSI VE CARE UNI T		0	-	0	0	
3.00		LABORATORY	200, 823	-	-		0	3.00
4.00		PHYSICAL THERAPY	200, 023	10,041		0	0	
4.00 5.00		ELECTROCARDI OLOGY	30, 098	1 505		0	0	4.00 5.00
						0	-	
6.00		ONCOLOGY	26, 844			0	0	
7.00		CARDIAC REHABILITATION	0	0	-	0	0	
8.00		CLINIC	0	0	C	0	0	8.00
9.00		EMERGENCY	0	0	C	0	0	9.00
10.00	0.00		0	0	C	0	0	
200.00			257, 765			0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0	-	-			1.00
2.00		INTENSIVE CARE UNIT	0	0	-	252, 385		2.00
3.00		LABORATORY	0	200, 823	C	0		3.00
4.00		PHYSI CAL THERAPY	0	0	C	1, 059		4.00
5.00		ELECTROCARDI OLOGY	0	30, 098				5.00
6.00		ONCOLOGY	0	26, 844	105, 414	105, 414		6.00
7.00		CARDIAC REHABILITATION	0	0	C	41, 500		7.00
8.00	90.00	CLINIC	0	0	C	600, 079		8.00
9.00	91.00	EMERGENCY	0	0	C	2, 528, 704		9.00
10.00	0.00		0	0	C	0		10.00
200.00			0	257, 765	134, 367	5, 294, 891		200.00
			•	•				•

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	JOHNSON MEMORI	AL HOSPITAL Provider CO	CN: 15-0001 F	In Lie Period: From 01/01/2019	u of Form CMS-2 Worksheet B Part I	2552-10
				o 12/31/2019	Date/Time Pre 8/27/2020 4:0	
		CAPI TAL REL	ATED COSTS		10/2//2020 110	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ON S	
	0	1.00	2.00	4.00	4. 01	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	-3, 552, 662	-3, 552, 662				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 4.01 00401 COMMUNI CATI ONS COMMUNI CATI ONS	4, 413, 837 8, 276, 280 342, 247	0 0	4, 413, 837 1, 979 0	8, 278, 259 24, 922	367, 169	2.00 4.00 4.01
4. 02 00402 DATA PROCESSING 4. 03 00403 MATERIALS MANAGEMENT 4. 04 00404 ADMITTING	3, 008, 131 370, 070 780, 229	0 0 0	2, 082, 951 9, 868 0	95, 352	37, 019 7, 952 9, 323	4.02 4.03 4.04
4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL	1, 734, 239 7, 827, 160	0	17, 417 43, 717	286, 826 619, 832	24, 131 21, 114	4.05 5.00
7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	2, 667, 603 190, 467 736, 205	0 0 0	67, 055 7, 384 6, 644	28, 577	13, 436 1, 371 3, 839	7.00 8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	357, 273 418, 247 1, 437, 537	0 0 0	30, 923 0 48, 743	138, 801	7, 129 0 12, 614	10.00 11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	155, 264 1, 481, 847	0	49, 164 8, 310	21, 795 159, 881	0 6, 307	14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	523, 329	0	12,007	139, 100	10, 146	16.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	2, 912, 048 1, 171, 873	0 0	194, 113 53, 033		28, 792 7, 678	
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	1, 171, 873 137 424, 963	0 0 0	03, 035 (0	0 0	41.00
ANCI LLARY SERVICE COST CENTERS	2, 122, 341	0	664, 082	534, 758	24, 131	50.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	67, 141 3, 036, 805	0	21, 145 511, 737		0 14, 259	53.00 54.00
60. 00 06000 LABORATORY	4, 260, 770	0	210, 397		14, 239	1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 188, 580 755, 276	0	23, 069 15, 047		4, 936 6, 855	
67.00 06700 OCCUPATI ONAL THERAPY	266, 810	0	3, 556		1, 645	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	138, 686	0	557 50, 570		1, 645 11, 791	68.00 69.00
70. 00 07000 ELECTROCARDI OLOGT	357, 593 12, 756	0	2, 755		548	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 698, 886	0	20, 904		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS	2, 690, 246 4, 626, 457	0 0		-	0	72.00 73.00
76.00 03020 ONCOLOGY	387, 244	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	256, 106	0	15, 388	38, 407	0	76.97
90. 00 09000 CLINIC	1, 669, 391	0	24, 609	198, 292	5, 758	90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 144, 419	0	46, 329	1, 069, 860	16, 178	91.00 92.00
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	722, 046	0	97	174, 094	6.307	101.00
SPECIAL PURPOSE COST CENTERS				1		
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	63, 077, 877	0	4, 246, 773	8, 222, 959	313, 696	113.00 118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 SOUTH CLINI C	79, 404 15, 926, 353 0	0 0 0	6, 649 159, 606	0	44, 972	190.00 192.00 192.01
192. 02 19202 WEST CLINIC	0	0	C	0	0	192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	74, 467 0	0	809 C	0	0	192.03 193.00
193. 01 19301 ADULT/CHILD CARE 193. 02 19302 PHYSI CI AN OFFICE BUILDING 193. 03 19303 OPTI FAST/FOUNDATI ON	1, 977 0	0		0	0	193. 01 193. 02 193. 03
194. 01 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR_CLINIC	73, 125 0	0		5, 911	2, 194	194.00 194.01
194. 02 07952 EDI NBURGH 194. 03 07953 JAI L	0 48, 000	0	C		0	194.02 194.03
194. 04 07953 JATE 194. 04 07954 ATHLETIC TRAINERS 200. 00 Cross Foot Adjustments	48,000	0	(0	0	194.03 194.04 200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	79, 281, 203	-3, 552, 662 -3, 552, 662		0 8, 278, 259	0	201.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2019	Worksheet B Part I	
			Ť		Date/Time Pre	
Cost Center Description	DATA	MATERI ALS	ADMI TTI NG	PATI ENT	8/27/2020 4:0 Subtotal	
	PROCESSI NG 4. 02	MANAGEMENT	4.04	ACCOUNTI NG	4A. 05	
GENERAL SERVICE COST CENTERS	4.02	4.03	4.04	4.05	4A. U5	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4. 01 00401 COMMUNI CATI ONS						4.00
4. 02 00402 DATA PROCESSI NG	5, 346, 611					4.02
4. 03 00403 MATERI ALS MANAGEMENT 4. 04 00404 ADMI TTI NG	115, 768 187, 624	599, 010 577				4.03 4.04
4. 05 00405 PATIENT ACCOUNTING	451, 095	1, 703				4.04
5. 00 00500 ADMI NI STRATI VE & GENERAL	641, 380	15, 344			9, 168, 547	5.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	89, 155 33, 267	406 131	0		3, 024, 893 261, 197	7.00
9. 00 00900 HOUSEKEEPI NG	0	897			929, 532	9.00
10. 00 01000 DI ETARY	73, 187	34, 569			571, 299	
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0 98, 469	0 10, 034	, o		557, 048 1, 958, 837	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	7, 562			233, 785	
15. 00 01500 PHARMACY	90, 485	0			1, 746, 830	•
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	192, 946	467	0	0	877, 995	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	295, 408	35, 867	58, 434	117, 685	4, 845, 625	30.00
31. 00 03100 I NTENSI VE CARE UNI T	183, 632	11, 038			1, 763, 836	•
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	0		-	137 480, 861	41.00 43.00
ANCILLARY SERVICE COST CENTERS					,	
50. 00 05000 OPERATING ROOM	480, 370	45, 498			4, 354, 755	1
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 200, 930	146 27, 678			163, 740 5, 113, 015	1
60. 00 06000 LABORATORY	239, 520	205, 701	185, 456		6, 044, 276	1
65. 00 06500 RESPIRATORY THERAPY	149, 034	18, 418			1, 775, 598	•
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	55, 888 23, 952	2, 846 0			1, 108, 627 390, 409	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	13, 307	9		3, 809	199, 197	68.00
69. 00 06900 ELECTROCARDI OLOGY	171, 656	1, 449			735, 839	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48 0			19, 351 2, 882, 527	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0			2, 808, 563	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			4, 929, 664	•
76. 00 03020 0NC0L0GY 76. 97 07697 CARDI AC REHABI LI TATI ON	63, 872 0	5, 256 1, 245			569, 263 321, 046	•
OUTPATIENT SERVICE COST CENTERS	-		1			
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	195, 608 211, 576	29, 566 24, 998			2, 305, 807 3, 983, 562	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	211, 570	24, 990	156,007	514, 195		91.00
OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	55, 888	2,006	4, 839	9, 745	975, 022	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 314, 017	483, 459	1, 196, 599	2, 410, 056	65, 100, 683	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	63, 872	2, 192	0	0	170, 576	190 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES	940, 778	113, 148		-	17, 289, 167	1
192. 01 19201 SOUTH CLINIC	0	0	-	-		192.01
192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER	3, 992	0 26	-		0 102, 598	192.02 192.03
193. 00 19300 NONPAI D WORKERS	0	0			0	193.00
193. 01 19301 ADULT/CHI LD CARE	0	0	-	0		193.01
193. 02 19302 PHYSI CLAN OFFI CE BUI LDI NG 193. 03 19303 OPTI FAST/FOUNDATI ON	0	0		0		193.02 193.03
194. 00 07950 PARTNERSHI P HFC	23, 952	185		Ő	105, 367	•
194. 01 07951 TRAFALGAR CLINIC	0	0	0	0		194.01
194. 02 07952 EDI NBURGH 194. 03 07953 JAI L	0	0		0		194.02 194.03
194. 04 07954 ATHLETI C TRAI NERS	0	0	0	0	0	194.04
200.00 Cross Foot Adjustments		-			0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 5, 346, 611	0 599, 010	0 1, 197, 118	0 2, 515, 411	-3, 552, 662 79, 281, 203	
		577,510	, , , , , , , , , , , , , , , , , , , ,	_, 0.0, .11	, 201, 200	00

Health Financial Systems	JOHNSON MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2019 Fo 12/31/2019	Worksheet B Part I Date/Time Pre 8/27/2020 4:0	pared:
Cost Center Description	ADMI NI STRATI V C E & GENERAL	PLANT	LAUNDRY & LINEN SERVICE		DI ETARY	
GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNI CATI ONS 4.02 00402 DATA PROCESSI NG						1.00 2.00 4.00 4.01 4.02
4. 03 00403 MATERI ALS MANAGEMENT 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 SERVICE 9. 00 00900 HOUSEKEEPI NG	9, 168, 547 376, 484 32, 509 115, 691	3, 401, 377 38, 387 29, 812	332, 093 60, 132	1, 135, 167		4.03 4.04 4.05 5.00 7.00 8.00 9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	71, 105 69, 331 243, 801	62, 546 66, 602 157, 554	C C	22, 682 53, 658	733, 994 0 0	11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	29, 097 217, 414 109, 277	27, 129 32, 670 <u>61, 939</u>	0	11, 126	0 0 0	14.00 15.00 16.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	603, 096	440, 344	88, 158	149, 966	671, 985	30.00
31. 00 03100 INTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	219, 531 17 59, 849	440, 344 125, 922 0 9, 980	22, 000 0	42, 885 0 0	671,985 62,009 0 0	31.00 41.00
ANCI LLARY SERVICE COST CENTERS	37,047	7,700		5, 577	0	45.00
50.00 05000 OPERATING ROOM	542,002	730, 701			0	•
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	20, 379 636, 376	6, 291 263, 979		=,	0	53.00 54.00
60. 00 06000 LABORATORY	752, 283	128, 525			0	60.00
65. 00 06500 RESPI RATORY THERAPY	220, 994	5, 972			0	65.00
66. 00 06600 PHYSI CAL THERAPY	137, 982	101, 204			0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	48, 591	21, 317			0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	24, 792 91, 584	1, 325 17, 245	-		0	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 408	2, 906			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	358, 765	0			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	349, 559	0		-	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	613, 556	0		-	0	
76. 00 03020 ONCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	70, 852 39, 958	111, 759 40, 095			0	76.00
OUTPATIENT SERVICE COST CENTERS	37,730	40,073		13,000	0	/0. //
90. 00 09000 CLINIC	286, 985	183, 885	1, 998	62, 625	0	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	495, 802	158, 624	49, 507	54, 022	0	91.00 92.00
101.00 10100 HOME HEALTH AGENCY	121, 353	20, 838	C	7, 097	0	101.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 961, 423	2, 847, 551	325, 778	946, 553	733, 994	113. 00 118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 230	20, 710	C	7, 053	0	190.00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	2, 151, 861	413, 965				190.00
192. 01 19201 SOUTH CLINIC	0	0	0,010	0		192.01
192. 02 19202 WEST CLINIC	0	0	0	0	0	192.02
192. 03 19203 DI ABETES CENTER	12, 770	6, 419	0	2, 186		192.03
193. 00 19300 NONPALD WORKERS 193. 01 19301 ADULT/CHILD CARE	481	0 77, 156		0 26, 277		193.00 193.01
193. 02 19302 PHYSICIAN OFFICE BUILDING	481	0		0		193.01
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	C	0	0	193.03
194. 00 07950 PARTNERSHI P HFC	13, 114	35, 576	0	12, 116		194.00
194. 01 07951 TRAFALGAR CLINIC	0	0		0		194.01 194.02
194. 02 07952 EDI NBURGH 194. 03 07953 JAI L	7, 668	0				194.02
194. 04 07954 ATHLETI C TRAI NERS	0	0		0		194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0			201.00
202.00 TOTAL (sum lines 118 through 201)	9, 168, 547	3, 401, 377	332, 093	1, 135, 167	733, 994	JZUZ. UU

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lieu	ı of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0001 P	eriod: rom 01/01/2019	Worksheet B	
			T		Part I Date/Time Pre	
Cost Center Description	CAFETERIA	NURSI NG	CENTRAL	PHARMACY	8/27/2020 4: 0 MEDI CAL	1 pm
		ADMI NI STRATI O	SERVICES &		RECORDS &	
	11.00	N 13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS		1	1			
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 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 4.03
4. 04 00404 ADMI TTI NG						4.04
4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL						4.05
7.00 00700 OPERATION OF PLANT						5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERIA	715, 663					11.00
13.00 01300 NURSING ADMINISTRATION	19, 835					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	3, 781			2, 020, 670		14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	20, 852			2,020,070	1, 091, 157	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	04.454	050.000			FF 404	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	94, 151 27, 333			0	55, 426 5, 711	
41. 00 04100 SUBPROVI DER – I RF	C	0	0	0	0	41.00
43. 00 04300 NURSERY	C	0	0	0	9, 132	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	54, 703	557, 135	0	0	145, 204	50.00
53. 00 05300 ANESTHESI OLOGY	C	0	0	0	22, 630	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	51, 420		0	0	229, 640 166, 620	54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	24, 591		0	0	29, 147	65.00
66. 00 06600 PHYSI CAL THERAPY	19, 295		0	0	18, 639	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	5, 853		-	0	5, 651 1, 711	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	9, 479		-	0	18, 437	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	179		-	0	405	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT			341, 539 0	0	48, 866 35, 527	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	0	2, 020, 670	91, 045	73.00
76. 00 03020 0NC0L0GY 76. 97 07697 CARDI AC REHABI LI TATI ON	7,772			0	3, 939	
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	3, 531	0	0	0	2, 973	76.97
90. 00 09000 CLI NI C	25, 139				54, 825	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	58, 985	600, 750	0	0	140, 529	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY	14, 821	0	0	0	5, 100	101.00
SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE		1	1			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	522, 032	2, 433, 685	341, 539	2, 020, 670	1, 091, 157	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	3, 495	0	0	ol	0	190.00
192. 00 19000 PHYSICIANS' PRIVATE OFFICES	171, 682			0		190.00
192. 01 19201 SOUTH CLINIC	C	0	0	0	0	192.01
192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER	1, 683	-	0	0		192.02 192.03
193. 00 19300 NONPAI D WORKERS	C		0	0		193.00
193. 01 19301 ADULT/CHI LD CARE	C	-	0	0		193.01
193. 02 19302 PHYSI CLAN OFFI CE BUILDING 193. 03 19303 OPTI FAST/FOUNDATI ON		-	0	0		193. 02 193. 03
194. 00 07950 PARTNERSHIP HFC	144	-	0	0		194.00
194. 01 07951 TRAFALGAR CLINIC	0	0	0	0		194.01
194. 02 07952 EDI NBURGH 194. 03 07953 JAI L		0	0	0		194.02 194.03
194. 04 07954 ATHLETI C TRAI NERS	16, 627	0	0	0		194.04
200.00Cross Foot Adjustments201.00Negative Cost Centers	C		_	~	0	200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	715, 663		341, 539	0 2, 020, 670	0 1, 091, 157	
						•

Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lieu of Form CM	IS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN		eriod: Worksheet E rom 01/01/2019 Part I	3
			Ť		Prepared: 1.01 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P 4. 00 00400 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 4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL					2.00 4.00 4.01 4.02 4.03 4.04 4.05 5.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.00 10.00
11. 00 01100 CAFETERIA					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY					14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
INPATIENT ROUTINE SERVICE COST CENTERS	7 007 (50		7 007 (50		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	7, 907, 659 2, 547, 611	0	7, 907, 659 2, 547, 611		30.00 31.00
41. 00 04100 SUBPROVI DER – I RF	154	0	154		41.00
43.00 04300 NURSERY	563, 221	0	563, 221		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	6, 689, 216	0	6, 689, 216		50.00
53.00 05300 ANESTHESI OLOGY	215, 183	0	215, 183		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	6, 413, 833	0	6, 413, 833		54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	7, 200, 179 2, 058, 336	0	7, 200, 179 2, 058, 336		60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	1, 427, 653	0	1, 427, 653		66.00
67.00 06700 OCCUPATI ONAL THERAPY	479, 081	0	479, 081		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	230, 454 881, 893	0	230, 454 881, 893		68.00 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	26, 239	0	26, 239		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 631, 697 3, 193, 649	0	3, 631, 697 3, 193, 649		71.00 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 654, 935	0	7, 654, 935		72.00
76. 00 03020 ONCOLOGY	801, 646	0	801, 646		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	421, 258	0	421, 258		76.97
90. 00 09000 CLINIC	2, 921, 264	0	2, 921, 264		90.00
91.00 09100 EMERGENCY	5, 541, 781	0	5, 541, 781		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS		0			92.00
101.00 10100 HOME HEALTH AGENCY	1, 144, 231	0	1, 144, 231		101.00
SPECIAL PURPOSE COST CENTERS					113.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	61, 951, 173	0	61, 951, 173		118.00
NONREI MBURSABLE COST CENTERS	222.074		222.071		100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	223, 064 20, 173, 972	0	223, 064 20, 173, 972		190.00 192.00
192. 01 19201 SOUTH CLINIC	0	0	0		192.01
192. 02 19202 WEST CLINIC		0	0		192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	125, 656 0	0	125, 656 0		192. 03 193. 00
193. 01 19301 ADULT/CHI LD CARE	107, 782	0	107, 782		193.01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG	0	0	0		193. 02 193. 03
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	0 166, 317	0	0 166, 317		193.03 194.00
194. 01 07951 TRAFALGAR CLINIC	0	Ő	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	69, 274 16, 627	0	69, 274 16, 627		194.03 194.04
200.00 Cross Foot Adjustments	0	0	0		200.00
201.00 Negative Cost Centers	-3, 552, 662	0	-3, 552, 662		201.00
202.00 TOTAL (sum lines 118 through 201)	79, 281, 203	J	79, 281, 203	I	202.00

Heal th ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	JOHNSON MEMORI	AL HOSPITAL Provider CO	CN: 15-0001 F	In Lie	u of Form CMS-: Worksheet B	2552-10
					rom 01/01/2019 o 12/31/2019	Part II Date/Time Pre	pared:
	· · · · · · · · · · · · · · · · · · ·		CAPI TAL REL	ATED COSTS		8/27/2020 4:0	
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BEDG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	1, 979	1, 979	1, 979	4.00
4.01	00401 COMMUNI CATI ONS	0	0	0	, v	6	4.01
4.02 4.03	00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT	0	0	2, 082, 951 9, 868		52 23	4.02 4.03
4.04	00404 ADMI TTI NG	0	0	(53	4.04
4.05	00405 PATIENT ACCOUNTING	0	0	17, 417		69	4.05
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	0	43, 717 67, 055		149 45	5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	7, 384		43	8.00
9.00	00900 HOUSEKEEPI NG	0	0	6, 644	6, 644	44	9.00
		0	0	30, 923		16	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	0	48, 743	-	33 84	11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	0	0	49, 164		5	14.00
	01500 PHARMACY	0	0	8, 310		38	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	12,007	12,007	33	16.00
30.00	03000 ADULTS & PEDI ATRI CS	0	0	194, 113	194, 113	283	30.00
	03100 I NTENSI VE CARE UNI T	0	0	53, 033		76	31.00
	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0			0 11	41.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	0	0		<u>, </u>	11	43.00
50.00	05000 OPERATI NG ROOM	0	0	664, 082		128	50.00
	05300 ANESTHESI OLOGY	0	0	21, 145		0	53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	0	511, 737 210, 397		134 132	54.00 60.00
65.00	06500 RESPIRATORY THERAPY	0	0	23, 069		71	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	15, 047		51	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	3, 556 557		18 9	67.00 68.00
	06900 ELECTROCARDI OLOGY	0	0	50, 570		20	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	2, 755		0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	20, 904		0	71.00
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0			0	72.00 73.00
76.00	03020 ONCOLOGY	0	0	3, 223	3, 223	21	76.00
76.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	15, 388	15, 388	9	76.97
90.00	09000 CLINIC	0	0	24, 609	24, 609	48	90.00
91.00	09100 EMERGENCY	0	0	46, 329		257	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS	0	0	97	97	42	101.00
	SPECIAL PURPOSE COST CENTERS		0	,,		12	
	11300 INTEREST EXPENSE					1.0/7	113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0	4, 246, 773	4, 246, 773	1, 967	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	6, 649	6, 649	3	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	159, 606			192.00
	19201 SOUTH CLINIC 19202 WEST CLINIC	0	0				192.01 192.02
	19203 DI ABETES CENTER	0	0	809			192.02
193.00	19300 NONPAI D WORKERS	0	0	C		0	193.00
	19301 ADULT/CHILD CARE	0	0	0	0		193.01
	19302 PHYSICIAN OFFICE BUILDING 19303 OPTIFAST/FOUNDATION	0	0				193. 02 193. 03
194.00	07950 PARTNERSHI P HFC	0	0		0	1	194.00
	07951 TRAFALGAR CLINIC	0	0	0	0		194.01
	07952 EDI NBURGH 07953 JAI L	0	0				194.02 194.03
	07955 JATE 07954 ATHLETIC TRAINERS	0	0		-		194.03
200.00	Cross Foot Adjustments				0		200.00
201.00 202.00		0	-3, 552, 662 -3, 552, 662				201.00 202.00
202.00			5, 552, 002	1 7, 413, 037	001, 175	1, 777	1202.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPLTAL		Inlie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		eriod:	Worksheet B	1002 10
				rom 01/01/2019 o 12/31/2019	Part II Date/Time Pre	pared:
Cost Center Description	COMMUNI CATI ON	DATA	MATERI ALS	ADMI TTI NG	8/27/2020 4:0 PATI ENT	1 pm
cost center bescription	S	PROCESSING	MANAGEMENT	ADMITTING	ACCOUNTING	
	4. 01	4.02	4.03	4.04	4.05	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01 00401 COMMUNI CATI ONS 4. 02 00402 DATA PROCESSI NG	6	2,083,008				4.01 4.02
4. 03 00403 MATERIALS MANAGEMENT	0	45, 102				4.02
4. 04 00404 ADMI TTI NG	0	73, 097	53	73, 203		4.04
4. 05 00405 PATI ENT ACCOUNTI NG 5. 00 00500 ADMI NI STRATI VE & GENERAL	0	175, 744 249, 878	156 1, 409	0	193, 386 0	4.05 5.00
7.00 00700 OPERATION OF PLANT	0	249,878 34,734	37	0	0	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	12, 960	12	0	0	8.00
9. 00 00900 HOUSEKEEPI NG	0	0	82	0	0	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	28, 513 0	3, 174 0	0	0	10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	38, 363		0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	694	0	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	35, 252 75, 171	0 43	0	0	15.00 16.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	/5, 1/1	43	0	0	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	115, 089	3, 293	3, 568	9, 046	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	71, 542		392	993	31.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0	0		0 203	0 514	41.00 43.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0	0	203	514	43.00
50. 00 05000 OPERATI NG ROOM	0	187, 149		9, 797	24, 838	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		1, 526	3, 868	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	78, 281 93, 315	2, 541 18, 888	15, 587 11, 324	39, 296 28, 711	54.00 60.00
65. 00 06500 RESPI RATORY THERAPY	0	58, 063		1, 965	4, 982	65.00
66. 00 06600 PHYSI CAL THERAPY	0	21, 774	261	1, 258	3, 188	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	9, 332 5, 184	0	381 115	967 293	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	66, 876		1, 204	3, 052	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	4	27	69	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	3, 297	8, 359	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	2, 397 6, 143	6, 077 15, 574	72.00 73.00
76. 00 03020 ONCOLOGY	0	24, 884	483	266	674	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	114	201	508	76.97
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	76, 208	2, 714	3, 699	9, 378	90.00
91. 00 09100 EMERGENCY	0	82, 429		9, 526	24, 152	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS		01 774	104	205	740	101 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	21, 774	184	295	/49	101.00
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5	1, 680, 714	44, 386	73, 171	185, 288	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24, 884	201	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	1	366, 523		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	0	1, 555 0		32 0		192.03 193.00
193. 01 19301 ADULT/CHI LD CARE	0	0	0	0		193.01
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 9, 332	0	0		193.03 194.00
194. 01 07951 TRAFALGAR CLINIC	0	9, 332	0	0		194.00
194. 02 07952 EDI NBURGH	0	0	0	Ō	0	194.02
194. 03 07953 JAI L	0	0	0	0		194.03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	0	0	0	0	194.04 200.00
201.00 Negative Cost Centers	0	0	0	О	0	200.00
202.00 TOTAL (sum lines 118 through 201)	6	2,083,008	54, 993	73, 203	193, 386	

Health Financial Systems	JOHNSON MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: ^om 01/01/2019	Worksheet B Part II	
			T		Date/Time Pre	pared:
Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPING	8/27/2020 4:0 DI ETARY	1 pm
cost center beschiption	E & GENERAL	PLANT	LINEN SERVICE	HOUSEREELTING	DILIAN	
	5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01 00401 COMMUNI CATI ONS						4.01
4. 02 00402 DATA PROCESSI NG 4. 03 00403 MATERI ALS MANAGEMENT						4.02 4.03
4. 04 00404 ADMI TTI NG						4.03
4. 05 00405 PATIENT ACCOUNTING						4.05
5. 00 00500 ADMI NI STRATI VE & GENERAL	295, 153	440.000				5.00
7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE	12, 121 1, 047	113, 992 1, 286				7.00 8.00
9. 00 00900 HOUSEKEEPI NG	3, 725	999		15, 604		9.00
10. 00 01000 DI ETARY	2, 289	2, 096		293	67, 833	1
11. 00 01100 CAFETERI A	2, 232	2, 232	0	312	0	
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	7, 849 937	5, 280 909		738 127	0	
15. 00 01500 PHARMACY	7,000	1, 095		153	0	14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	3, 518	2,076		290	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	19, 416	14, 757	6, 024	2,061	62, 102	
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	7,068	4, 220 0	1, 504 0	589 0	5, 731 0	31.00 41.00
43. 00 04300 NURSERY	1, 927	334	0	47	0	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	17, 450	24, 492		3, 418	0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	656 20, 488	211 8, 847	0 2, 016	29 1, 236	0	53.00 54.00
60. 00 06000 LABORATORY	24, 219	4, 307	0	602	0	60.00
65. 00 06500 RESPI RATORY THERAPY	7, 115	200	0	28	0	65.00
66.00 06600 PHYSI CAL THERAPY	4, 442	3, 392	508	474	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	1, 564 798	714 44	0	100 6	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	2,949	578	-	81	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	78	97	0	14	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI		0	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS	11, 254 19, 753	0	0	0	0	72.00 73.00
76. 00 03020 ONCOLOGY	2, 281	3, 745	0	523	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 286	1, 344	0	188	0	76.97
OUTPATI ENT SERVICE COST CENTERS	0.000	(1()	407	0.14		
90.00 09000 CLINIC 91.00 09100 EMERGENCY	9, 239 15, 962	6, 163 5, 316		861 743	0	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT P		5, 510	5, 505	743	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	3, 907	698	0	98	0	101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 throug	h 117) 224, 121	95, 432	22, 264	13, 011	67,833	118.00
NONREI MBURSABLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANT		694		97		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 192.01 19201 SOUTH CLINIC	69, 254	13, 873	432	1, 938 0		192.00 192.01
192. 02 19202 WEST CLINIC	0	0	0	0		192.01
192. 03 19203 DI ABETES CENTER	411	215	0	30		192.03
193.00 19300 NONPAI D WORKERS	0	0	0	0		193.00
193. 01 19301 ADULT/CHI LD CARE	15	2, 586	0	361		193.01
193. 02 19302 PHYSI CLAN OFFICE BUILDING 193. 03 19303 OPTI FAST/FOUNDATI ON	0	0		0		193.02 193.03
194. 00 07950 PARTNERSHI P HFC	422	1, 192	0	167	0	194.00
194. 01 07951 TRAFALGAR CLINIC	0	0	0	0	0	194.01
194. 02 07952 EDI NBURGH	0	0	0	0		194.02
194. 03 07953 JAI L 194. 04 07954 ATHLETI C_TRAI NERS	247	0		0		194.03 194.04
200.00 Cross Foot Adjustments		0	0	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201) 295, 153	113, 992	22, 696	15, 604	67, 833	202.00

Health Financial Systems	JOHNSON MEMOR	ιδι μοςριτδι		Inlieu	ı of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	SOUNDER MEMORY	Provi der C		Period:	Worksheet B	2002 10
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	epared:
Cost Conton Description			CENTRAL	PHARMACY	8/27/2020 4: 0 MEDI CAL	<u>)1 pm</u>
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY	RECORDS &	
		N	SUPPLY		LI BRARY	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	16.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS						4.00
4. 02 00402 DATA PROCESSI NG						4.02
4. 03 00403 MATERIALS MANAGEMENT						4.03
4. 04 00404 ADMI TTI NG 4. 05 00405 PATI ENT ACCOUNTI NG						4.04 4.05
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERIA	4, 809					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	133					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	25					14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	140				93, 278	1
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	633				4, 734 488	1
41. 00 04100 SUBPROVI DER – I RF	0				488	1
43. 00 04300 NURSERY	0			0 0	780	1
ANCI LLARY SERVICE COST CENTERS	240	22.274	(0 0	12 402	
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	368				12, 403 1, 933	
54.00 05400 RADI OLOGY-DI AGNOSTI C	345			0 0	19, 689	1
	435				14, 232	1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	165				2, 490 1, 592	1
67. 00 06700 OCCUPATI ONAL THERAPY	39				483	1
68.00 06800 SPEECH PATHOLOGY	20				146	1
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	64	0			1, 575 35	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-	53, 47		4, 174	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0				3, 035	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03020 0NCOLOGY	0 52				7,777	1
76. 00 03020 0NCOLOGY 76. 97 07697 CARDI AC REHABI LI TATI ON	24				336 254	
OUTPATIENT SERVICE COST CENTERS		-				
90. 00 09000 CLINIC	169			0	4, 683	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	396	25, 206		0 0	12,003	91.00 92.00
OTHER REI MBURSABLE COST CENTERS						/2:00
101.00 10100 HOME HEALTH AGENCY	100	0	(0 0	436	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE			1	1		113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 508	102, 111	53, 47	51, 933	93, 278	118.00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	23					190.00 192.00
192. 01 19201 SOUTH CLINIC	0					192.00
192. 02 19202 WEST CLINIC	0			0 0		192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPAI D WORKERS	11					192.03 193.00
193. 01 19301 ADULT/CHI LD CARE	0	-				193.00
193.02 19302 PHYSICIAN OFFICE BUILDING	0	0		0 0	0	193.02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	0	0				193.03 194.00
194. 00 07950 PARTNERSHIP_HFC 194. 01 07951 TRAFALGAR_CLINIC		0 0				194.00
194. 02 07952 EDI NBURGH	0	0		0	0	194.02
194. 03 07953 JALL	0	0				194.03
194.0407954ATHLETICTRAINERS200.00Cross Foot Adjustments	112	0			C	194.04 200.00
201.00 Negative Cost Centers	0			0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	4, 809	102, 111	53, 47	51, 933	93, 278	202.00

Health Financial Systems	JOHNSON MEMORI	AL_HOSPITAL		In Lieu	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0001	Period: From 01/01/2019	Worksheet B Part II
				To 12/31/2019	Date/Time Prepared: 8/27/2020 4:01 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01 00401 COMMUNI CATI ONS					4.01
4. 02 00402 DATA PROCESSI NG 4. 03 00403 MATERI ALS MANAGEMENT					4.02
4. 04 00404 ADMI TTI NG					4.04
4.05 00405 PATIENT ACCOUNTING					4.05
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT					5.00 7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE					8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON					11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS					16.00
30. 00 03000 ADULTS & PEDIATRICS	475, 352	0	475, 35	52	30.00
31. 00 03100 I NTENSI VE CARE UNI T	158, 513	0	158, 51		31.00
41.00 04100 SUBPROVIDER - IRF	1	0		1	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 816	0	3, 81	16	43.00
50. 00 05000 OPERATI NG ROOM	975, 496	0	975, 49	96	50.00
53.00 05300 ANESTHESI OLOGY	29, 381	0	29, 38		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	700, 197	0	700, 19		54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	406, 562 99, 839	0	406, 56 99, 83		65.00
66. 00 06600 PHYSI CAL THERAPY	52, 117	0	52, 11		66.00
67.00 06700 OCCUPATI ONAL THERAPY	17, 154	0	17, 15		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	7, 173 127, 337	0	7, 17 127, 33		68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 080	0	3, 08		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	101, 761	0	101, 76		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	22, 763 101, 180	0	22, 76 101, 18		72.00 73.00
76. 00 03020 0NC0L0GY	36, 488	0	36, 48		75.00
76. 97 07697 CARDI AC REHABI LI TATI ON	19, 316	0	19, 31		76. 97
	127.000	0	127.00	20	00_00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	137, 908 227, 997	0	137, 90 227, 99		90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		Ő			92.00
OTHER REI MBURSABLE COST CENTERS	00,000				101.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	28, 380	0	28, 38	30	101.00
113. 00 11300 I NTEREST EXPENSE					113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 731, 811	0	3, 731, 81	11	118.00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 234	0	33, 23	34	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	631, 186	0	631, 18		192.00
192. 01 19201 SOUTH CLINIC	0	0		0	192.01
192. 02 19202 WEST CLINIC 192. 03 19203 DI ABETES CENTER	0	0	2.45	0	192.02
192. 03 19203 DI ABETES CENTER 193. 00 19300 NONPALD WORKERS	3, 150 0	0	3, 15	0	192. 03 193. 00
193. 01 19301 ADULT/CHI LD CARE	2, 962	Ō	2,96	52	193.01
193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG	0	0		0	193.02
193. 03 19303 OPTI FAST/FOUNDATI ON 194. 00 07950 PARTNERSHI P HFC	0 11, 132	0	11, 13	0	193. 03 194. 00
194. 01 07951 TRAFALGAR CLINIC	0	0	11, 13	0	194.00
194. 02 07952 EDI NBURGH	0	0		0	194.02
194. 03 07953 JALL	250	0	25		194.03
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	112 0	0	11	0	194.04 200.00
201.00 Negative Cost Centers	-3, 552, 662	0	-3, 552, 66		201.00
202.00 TOTAL (sum lines 118 through 201)	861, 175	0	861, 17	75	202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	JOHNSON MEMORI	AL HOSPITAL Provider CO	CN: 15-0001 P	In Lieu eriod:	u of Form CMS-: Worksheet B-1	
				F	rom 01/01/2019 o 12/31/2019	Date/Time Pre	pared:
		CAPI TAL REL	ATED COSTS			8/27/2020 4:0	
	Cost Center Description	NEW BLDG & FI XT (TOTAL FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	COMMUNI CATI ON S (# NON PT PHONES)	DATA PROCESSI NG (WORK ORDERS)	
		1.00	2.00	4.00	4.01	4.02	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 4.\ 01\\ 4.\ 02\\ 4.\ 03\\ 4.\ 04\\ 4.\ 05\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 DATA PROCESSING 00403 MATERIALS MANAGEMENT 00404 ADMITTING 00405 PATIENT ACCOUNTING 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	273, 798 2, 984 393 6, 260 3, 826 2, 239 6, 650 9, 526 28, 905 2, 404 1, 867 3, 917 4, 171 9, 867 1, 699	2, 558, 512 1, 147 0 1, 207, 398 5, 720 0 10, 096 25, 341 38, 869 4, 280 3, 851 17, 925 0 28, 254 28, 498	29, 205, 219 87, 923 770, 890 336, 396 773, 909 1, 011, 906 2, 186, 734 660, 564 100, 817 641, 899 240, 671 489, 681 1, 239, 863 76, 893	1, 339 135 29 34 88 77 49 5 14 26 0 46	4, 018 87 141 339 482 67 25 0 55 0 74	7.00 8.00 9.00
15.00	01500 PHARMACY	2, 046	4, 817	564, 052	23	68	15.00
16.00 30.00	01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 879	6, 960	490, 739		222	
31.00	03100 I NTENSI VE CARE UNI T	7, 886	30, 741	1, 119, 267	28	138	31.00
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	0 625	0	0 161, 883	0	0	41.00 43.00
	ANCILLARY SERVICE COST CENTERS						
50.00 53.00 54.00 60.00 65.00 66.00 67.00 68.00	05000 OPERATING ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	45, 761 394 16, 532 8, 049 374 6, 338 1, 335 83 1, 200	384, 940 12, 257 296, 632 121, 958 13, 372 8, 722 2, 061 323	0 1, 965, 956 1, 941, 363 1, 039, 211 743, 133 266, 810 138, 624	52 68 18 25 6 6	361 0 151 180 112 42 18 10	53.00 54.00 60.00 65.00 66.00 67.00 68.00
71.00 72.00 73.00 76.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL_SUPPLIES_CHARGED_TO_PATIENTS 07200 MPLDEVCHARGED_TO_PATIENT 07300 DRUGS_CHARGED_TO_PATIENTS 03020 ONCOLOGY 07697 CARDIAC_REHABILITATION	1, 080 182 0 0 0 6, 999 2, 511	29, 313 1, 597 12, 117 0 1, 868 8, 920		2 0 0 0 37		71.00 72.00
90.00	OUTPATIENT SERVICE COST CENTERS	11, 516	14, 265	699, 565	21	147	90.00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	9, 934	26, 855			159	
101.00	10100 HOME HEALTH AGENCY	1, 305	56	614, 193	23	42	101.00
113. 00 118. 00		239, 114	2, 461, 672	29, 010, 125	1, 144	3, 242	113. 00 118. 00
192.00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFICES 19201 SOUTH CLINIC	1, 297 25, 925 0	3, 854 92, 517 0	50, 611 0		707	190. 00 192. 00 192. 01
192. 02 192. 03	19202 WEST CLINIC 19203 DI ABETES CENTER 19300 NONPAI D WORKERS	0 402 0	0 469 0	0 73, 794	0	0 3	192.02 192.03 193.00
193. 01 193. 02	19301 ADULT/CHILD CARE 19302 PHYSICIAN OFFICE BUILDING	4, 832 0	0	1, 836 0	5	0 0	193. 01 193. 02
194.00 194.01 194.02 194.03 194.04	19303 OPTI FAST/FOUNDATI ON 07950 PARTNERSHI P HFC 07951 TRAFALGAR CLINI C 07952 EDI NBURGH 07953 JAI L 07954 ATHLETI C TRAINERS	0 2, 228 0 0 0 0	0 0 0 0 0 0	0 20, 853 0 0 48, 000 0	0 0	18 0 0 0	193.03 194.00 194.01 194.02 194.03 194.04
200.00 201.00 202.00	Negative Cost Centers	-3, 552, 662	4, 413, 837	8, 278, 259	367, 169	5, 346, 611	200. 00 201. 00 202. 00
203.00		0. 000000	1. 725158	0. 283451	274. 211352	1, 330. 664759	203.00

Health Fir	nancial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2019	Worksheet B-1	
					o 12/31/2019		
		CAPI TAL REL	ATED COSTS				
	Cost Center Description	NEW BLDG & FI XT (TOTAL	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ON S (# NON PT	DATA PROCESSI NG (WORK	
		FEET)	VALUE)	(GROSS SALARI ES)	PHONES)	ORDERS)	
		1.00	2.00	4.00	4.01	4.02	
204.00	Cost to be allocated (per Wkst. B, Part II)			1, 979	6	2, 083, 008	204.00
205.00	Unit cost multiplier (Wkst. B, Part			0. 000068	0. 004481	518. 419114	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	JOHNSON MEMORIA	Provider CC		Period:	u of Form CMS-2 Worksheet B-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	pared
Cost Center Description	MATERI ALS MANAGEMENT (SUPPLY USAGE)	ADMI TTI NG (GROSS CHARGES)	PATI ENT ACCOUNTI NG (GROSS CHARGES)	Reconciliatio n	E & GENERAL (ACCUM. COST))1 pm
	4.03	4.04	4.05	5A	5.00	-
GENERAL SERVI CE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00402 DATA PROCESSING 4.01 4.02 00403 MATERIALS MANAGEMENT 4.03 00403 MATERIALS MANAGEMENT 4.04 00404 ADMITTING 5.00 00500 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 DIETARY	4, 131, 551 3, 981 11, 748 105, 831 2, 798 906 6, 184 238, 434	246, 128, 805 0 0 0 0 0 0 0 0 0		0 -9, 168, 547 0 0 0 0 0 0 0 0 0 0 0 0	73, 665, 318 3, 024, 893 261, 197 929, 532 571, 299	7.0 8.0 9.0
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY	0 69, 210 52, 155 0 3, 224	0 0 0 0		0 0 0 0 0 0 0 0 0 0	557, 048 1, 958, 837 233, 785 1, 746, 830 877, 995	13.0 14.0 15.0
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 41.00 04100 SUBPROVIDER - IRF 43.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS ANCILLARY	247, 385 76, 133 0 0	12, 013, 550 1, 318, 195 0 682, 972	12, 013, 55 1, 318, 19 682, 97	5 0 0 0	4, 845, 625 1, 763, 836 137 480, 861	31.0 41.0
50. 00 05000 OPERATING ROOM	313, 814	32, 986, 001	32, 986, 00	1 0	4, 354, 755	50.0
53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 50.00 06000 LABORATORY 55.00 06500 RESPI RATORY 55.00 06500 THERAPY	1, 008 190, 905 1, 418, 771 127, 035	5, 136, 959 52, 140, 801 38, 128, 318 6, 616, 358	5, 136, 95 52, 140, 80 38, 128, 31 6, 616, 35	1 0 8 0 8 0	163, 740 5, 113, 015 6, 044, 276 1, 775, 598	54.0 60.0 65.0
56.00 06600 PHYSI CAL THERAPY 57.00 06700 0CCUPATI ONAL THERAPY 58.00 06800 SPEECH PATHOLOGY 59.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCEPHALOGRAPHY	19, 632 0 62 9, 991 333	4, 234, 136 1, 283, 635 388, 790 4, 052, 981 92, 113	4, 234, 13 1, 283, 63 388, 79 4, 052, 98 92, 11	5 0 0 0 1 0	1, 108, 627 390, 409 199, 197 735, 839 19, 351	67.0 68.0 69.0
71.0007100MEDICAL SUPPLIES CHARGED TO PATIENTS72.0007200IMPL. DEV. CHARGED TO PATIENT73.0007300DRUGS CHARGED TO PATIENTS76.0003020ONCOLOGY	0 0 36, 253	11, 100, 756 8, 070, 737 20, 682, 600 894, 781	11, 100, 75 8, 070, 73 20, 682, 60 894, 78	6 0 7 0 0 0	2, 882, 527 2, 808, 563 4, 929, 664 569, 263	71.0 72.0 73.0 76.0
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	8, 587	675, 276	675, 27	6 0	321, 046	76.9
20.00 09000 CLINIC 21.00 09100 EMERGENCY 22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	203, 927 172, 419	12, 454, 479 32, 073, 844	12, 454, 47 32, 073, 84		2, 305, 807 3, 983, 562	
OTHER REIMBURSABLE COST CENTERS	13, 837	994, 817	994, 81	7 0	975, 022	101. (
SPECIAL PURPOSE COST CENTERS 13.00 11300 INTEREST EXPENSE 18.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	3, 334, 563	246, 022, 099	246, 022, 09	9 -9, 168, 547	55, 932, 136	113. (118. (
90. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 92. 01 19201 SOUTH CLINIC	15, 120 780, 418 0	0 0 0	10, 648, 24	0 0		192. (192. (
92. 02 19202 WEST CLINIC 92. 03 19203 DI ABETES CENTER 93. 00 19300 NONPAID WORKERS 93. 01 19301 ADULT/CHILD CARE	0 177 0 0	0 106, 706 0 0		0 0 6 0 0 0 0 0	102, 598 0 3, 868	193. 193. (
93. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG 93. 03 19303 OPTI FAST/FOUNDATI ON 94. 00 07950 PARTNERSHI P HFC 94. 01 07951 TRAFALGAR CLI NI C	0 0 1, 273 0	0 0 0 0		0 0 0 0 0 0 0 0	0 105, 367	193. 193. 194. 194.
94. 02 07952 EDI NBURGH 94. 03 07953 JAI L 94. 04 07954 ATHLETIC TRAINERS 00. 00 Cross Foot Adjustments 01. 00 Negative Cost Centers	0 0 0	0 0 0		0 0 0 0 0 0	61, 606	194. 200.
001.00 Negative Cost Centers 002.00 Cost to be allocated (per Wkst. B, Part L)	599, 010	1, 197, 118	2, 515, 41	1	9, 168, 547	201. 202.
203.00 204.00 Part I) 204.00 Cost to be allocated (per Wkst. B, Part I)	0. 144984 54, 993	0. 004864 73, 203	0. 00979 193, 38		0. 124462 295, 153	

Heal th Fi	nancial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider CO	Provider CCN: 15-0001 F		Worksheet B-1	
					Го 12/31/2019	Date/Time Pre 8/27/2020 4:0	
	Cost Center Description	MATERI ALS	ADMI TTI NG	PATI ENT	Reconciliatio	ADMI NI STRATI V	
		MANAGEMENT	(GROSS	ACCOUNTI NG	n	E & GENERAL	
		(SUPPLY	CHARGES)	(GROSS		(ACCUM.	
		USAGE)		CHARGES)		COST)	
		4.03	4.04	4.05	5A	5.00	
205.00	Unit cost multiplier (Wkst. B, Part	0. 013310	0. 000297	0.00075	3	0. 004007	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	JOHNSON MEMORI	AL HOSPITAL Provider C	CN: 15-0001 P	In Lie eriod:	u of Form CMS-: Worksheet B-1	
			F	rom 01/01/2019 0 12/31/2019	Date/Time Pre	epared
Cost Center Description	OPERATI ON OF PLANT (TOTAL FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (TOTAL FEET)	DI ETARY (MEALS SERVED)	8/27/2020 4: C CAFETERI A (HOURS PAI D)) <u>1 pm</u>
CENEDAL SEDVICE COST CENTEDS	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.0
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.01 00401 COMMUNI CATIONS 4.02 00402 DATA PROCESSI NG 4.02 00402 DATA PROCESSI NG 4.03 00403 MATERI ALS MANAGEMENT 4.04 00404 ADMI TTI NG 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 0.01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS	213, 015 2, 404 1, 867 3, 917 4, 171 9, 867 1, 699 2, 046 3, 879	370, 862 67, 152 8, 647 0 0 0 0 0 0	208, 744 3, 917 4, 171 9, 867 1, 699 2, 046	17, 862 0 0 0 0	832, 087 23, 062 4, 396 14, 685 24, 244	2.0 4.0 4.0 4.0 4.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0 15.0
30. 00 03000 ADULTS & PEDI ATRI CS	27, 577	98, 449	27, 577	16, 353	109, 468	30.0
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	7, 886 0	24, 568 0			31, 780 0	
43. 00 04300 NURSERY	625	0			0	
ANCI LLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	45, 761	62, 386	45, 761	0	63, 602	50.0
53. 00 05300 ANESTHESI OLOGY	394	02, 500	394		03, 002	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	16, 532 8, 049	32, 945 0			59, 785	
65. 00 06500 RESPI RATORY THERAPY	374	0	374		75, 230 28, 592	
66. 00 06600 PHYSI CAL THERAPY	6, 338	8, 308			22, 434	
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	1, 335 83	0	1, 335 83		6, 805 3, 463	
69. 00 06900 ELECTROCARDI OLOGY	1, 080	3, 837			11, 021	
70.00 07000 ELECTROENCEPHALOGRAPHY	182	0	182		208	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
76. 00 03020 ONCOLOGY 76. 97 07697 CARDLAC REHABILITATION	6, 999	0			9,036	
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	2, 511	0			4, 105	76.9
90. 00 09000 CLINIC	11, 516	2, 231				
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 934	55, 287	9, 934	0	68, 581	91.0
OTHER REIMBURSABLE COST CENTERS			1			
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	1, 305	0	1, 305	0	17, 232	101.0
113. 00 11300 I NTEREST EXPENSE						113.0
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	178, 331	363, 810	174,060	17, 862	606, 958	118.0
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 297	0	1, 297	0	4, 064	190. 0
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	25, 925	7, 052			199, 608	
192. 01 19201 SOUTH CLINIC 192. 02 19202 WEST CLINIC	0	0	-	-		192.0 192.0
192. 03 19203 DI ABETES CENTER	402	0	402	-		192.0
193. 00 19300 NONPALD WORKERS	0	0	0	Ű		193.0
193. 01 19301 ADULT/CHI LD CARE 193. 02 19302 PHYSI CI AN OFFI CE BUI LDI NG	4, 832	0	4,832	0		193. 0 193. 0
193. 03 19303 OPTI FAST/FOUNDATI ON	0	0	0	0	0	193.0
194. 00 07950 PARTNERSHI P HFC 194. 01 07951 TRAFALGAR CLI NI C	2, 228	0	2, 228	0		194.0 194.0
194. 02 07952 EDI NBURGH	0	0	0	0		194.0
194. 03 <mark>07953</mark> JAI L	0	0	0	0	0	194.0
194.04 07954 ATHLETIC TRAINERS 200.00 Cross Foot Adjustments	0	0	0	0	19, 332	194.0 200.0
200.00 Cross root adjustments 201.00 Negative Cost Centers						200.0
202.00 Cost to be allocated (per Wkst. B, Part I)	3, 401, 377	332, 093	1, 135, 167	733, 994	715, 663	
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II)	15. 967782 113, 992	0. 895462 22, 696			0. 860082 4, 809	203. 0 204. 0

Health Fin	ancial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOC	CATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2019	Worksheet B-1	
					To 12/31/2019		pared: 1 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(TOTAL	(MEALS	(HOURS	
		(TOTAL	(POUNDS OF	FEET)	SERVED)	PAID)	
		FEET)	LAUNDRY)				
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part	0. 535136	0. 061198	0.07475	3. 797615	0. 005779	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Heal th Financial COST ALLOCATION	Systems - STATISTICAL BASIS	JOHNSON MEMORI	AL HOSPITAL Provider CC		Period:	u of Form CMS-2552 Worksheet B-1
					From 01/01/2019 To 12/31/2019	Date/Time Prepare 8/27/2020 4:01 pm
	: Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS) 13. 00	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14. 00	PHARMACY (COSTED REQUIS.) 15.00	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16.00	
	ERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT		1			1.
2.00 00200 CAP 4.00 00400 EMPL 4.01 00401 COM 4.02 00402 DAT 4.03 00403 MATE 4.04 00404 ADMI 4.05 00405 PATI 5.00 00500 ADMI 7.00 00700 DEE 8.00 00800 LAUM 9.00 00900 HOUS 10.00 01100 CAFE 13.00 01300 NURS	REL COSTS-MVBLE EQUIP OYEE BENEFITS DEPARTMENT NUNICATIONS A PROCESSING ERIALS MANAGEMENT TTING ENT ACCOUNTING NISTRATIVE & GENERAL RATION OF PLANT IDRY & LINEN SERVICE SEKEEPING TARY TTERIA SING ADMINISTRATION RAL SERVICES & SUPPLY	277, 827 4, 396 0	100 0	10	0	2. 4. 4. 4. 4. 4. 4. 5. 7. 8. 9. 10. 11. 13. 14.
16.00 01600 MEDI	CAL RECORDS & LIBRARY	0	0		0 247, 850, 961	16.
30.00 03000 ADUL 31.00 03100 INTE 41.00 04100 SUBF 43.00 04300 NURS		109, 468 31, 780 0 0	0 0 0 0		0 12, 591, 184 0 1, 297, 334 0 0 0 2, 074, 424	30. 31. 41. 43.
	SERVICE COST CENTERS	63, 602	0		0 32, 986, 001	50.
53.00 05300 ANES	STHESI OLOGY	0	0		0 5, 140, 820	53.
60.00 06000 LABO		0	0		0 52, 140, 801 0 37, 851, 089	60.
	PIRATORY THERAPY SI CAL THERAPY	0	0		0 6, 621, 278 0 4, 234, 136	65. 66.
67.00 06700 OCCL	IPATI ONAL THERAPY	0	0		0 1, 283, 635	67.
	ECH PATHOLOGY CTROCARDI OLOGY	0	0 0		0 388, 790 0 4, 188, 412	68. 69.
	TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENTS	0	0 100		0 92, 113 0 11, 100, 756	70.
72.00 07200 I MPL	DEV. CHARGED TO PATIENT	0	0		0 8, 070, 737	72.
73.00 07300 DRU0 76.00 03020 0NC0	S CHARGED TO PATIENTS	0	0	10	0 20, 682, 600 0 894, 781	73.
76. 97 07697 CARE	DIAC REHABILITATION	0	0		0 675, 276	76.
90.00 09000 CLIN	T SERVICE COST CENTERS	o	0		0 12, 454, 479	90.
91.00 09100 EMEF		68, 581	0		0 31, 923, 818	91. 92.
OTHER REIM	MBURSABLE COST CENTERS					
101.00 10100 HOME SPECIAL PU	E HEALTH AGENCY JRPOSE COST CENTERS	0	0		0 1, 158, 497	101.
113.00 11300 I NTE	REST EXPENSE	277 027	100	10	0 047 050 0/1	113.
	TOTALS (SUM OF LINES 1 through 117) RSABLE COST CENTERS	277, 827	100	10	0 247, 850, 961	118.
	, FLOWER, COFFEE SHOP & CANTEEN	0	0 0		0 0 0 0	190. 192.
192.01 19201 SOUT	TH CLINIC	0	0		0 0	192.
192. 02 19202 WEST 192. 03 19203 DI AE		0	0		0 0	192. 192.
193.00 19300 NONF	PALD WORKERS	0	0		0 0	193.
193. 01 19301 ADUL 193. 02 19302 PHYS	T/CHILD CARE SICIAN OFFICE BUILDING	0	0		0 0	193. 193.
193. 03 19303 OPTI	FAST/FOUNDATI ON	0	0		0 0	193.
194. 00 07950 PART 194. 01 07951 TRAF		0	0		0 0 0 0	194. 194.
194. 02 07952 EDI N		0	0		0 0	194. 194
194. 03 07953 JAI L 194. 04 07954 ATHL		0	0		0 0 0 0	194. 194.
200. 00 Cros	ss Foot Adjustments					200.
202.00 Cost	itive Cost Centers : to be allocated (per Wkst. B,	2, 433, 685	341, 539	2, 020, 67	0 1, 091, 157	201. 202.
203.00 Part	:I) cost multiplier (Wkst. B, Part I)	8. 759714	3, 415. 390000	20 206 70000	0 0.004402	203.
	to be allocated (per Wkst. B,	102, 111	3, 415. 390000 53, 477	51, 93		203. 204.

Health Fin	ancial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider CC	Provider CCN: 15-0001		Worksheet B-1	
					From 01/01/2019 To 12/31/2019		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &		
		N	SUPPLY	REQUIS.)	LI BRARY		
		(DI RECT	(COSTED		(GROSS		
		NRSING HRS)	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16.00		
205.00	Unit cost multiplier (Wkst. B, Part	0. 367534	534. 770000	519. 33000	0.000376		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	JOHNSON MEMORI				u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0001	Period: From 01/01/2019	Worksheet C Part I	
				To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	n pii
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
·	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,	-				
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-1					
30. 00 03000 ADULTS & PEDIATRICS	7, 907, 659		7, 907, 65		7, 907, 659	
31.00 03100 INTENSIVE CARE UNIT	2, 547, 611		2, 547, 6		2, 547, 611	
41. 00 04100 SUBPROVI DER – I RF	154		15		154	
43. 00 04300 NURSERY	563, 221		563, 22	21 0	563, 221	43.00
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 O5000 OPERATING ROOM	6, 689, 216		6, 689, 21		6, 689, 216	
53. 00 05300 ANESTHESI OLOGY	215, 183		215, 18		215, 183	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 413, 833		6, 413, 83		6, 413, 833	
60. 00 06000 LABORATORY	7, 200, 179		7, 200, 1		7, 200, 179	
65. 00 06500 RESPI RATORY THERAPY	2,058,336		_, _, _, _, _,		2, 058, 336	
66. 00 06600 PHYSI CAL THERAPY	1, 427, 653	0	1 1/ 12/ 0		1, 427, 653	
67.00 06700 OCCUPATI ONAL THERAPY	479, 081	0	479, 08		479, 081	
68.00 06800 SPEECH PATHOLOGY	230, 454	0	230, 45		230, 454	
69. 00 06900 ELECTROCARDI OLOGY	881, 893		881, 89		910, 846	
70. 00 07000 ELECTROENCEPHALOGRAPHY	26, 239		26, 23			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 631, 697		3, 631, 69		3, 631, 697	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 193, 649		3, 193, 64		3, 193, 649	
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 654, 935		7, 654, 93		7, 654, 935	
76.00 03020 ONCOLOGY	801, 646		801, 64		907,060	
76. 97 07697 CARDI AC REHABI LI TATI ON	421, 258		421, 25	58 0	421, 258	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	2, 921, 264		2, 921, 20		2, 921, 264	
91.00 09100 EMERGENCY	5, 541, 781		5, 541, 78		5, 541, 781	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 132, 225		1, 132, 22	25	1, 132, 225	92.00
OTHER REIMBURSABLE COST CENTERS	1 1 1 1 001					
101.00 10100 HOME HEALTH AGENCY	1, 144, 231		1, 144, 23	31	1, 144, 231	101.00
SPECIAL PURPOSE COST CENTERS			1	1		112 00
113.00 11300 INTEREST EXPENSE	(2,002,000	_	(2,002,0)	104 047		113.00
200.00 Subtotal (see instructions)	63, 083, 398				63, 217, 765	
201.00 Less Observation Beds	1, 132, 225		1, 132, 22		1, 132, 225	
202.00 Total (see instructions)	61, 951, 173	0	61, 951, 1	73 134, 367	62,085,540	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:	Worksheet C	
				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2017	8/27/2020 4:0	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	10, 710, 704		10, 710, 70			30.00
31.00 03100 I NTENSI VE CARE UNI T	1, 297, 334		1, 297, 33			31.00
41.00 04100 SUBPROVIDER - IRF	0			0		41.00
43. 00 04300 NURSERY	2,074,424		2,074,42	24		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	6, 276, 411	26, 709, 590			0.00000	
53. 00 05300 ANESTHESI OLOGY	832, 328	4, 308, 492			0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 204, 270	45, 936, 531	52, 140, 80		0.00000	
60. 00 06000 LABORATORY	7, 838, 654	30, 012, 435			0.00000	
65. 00 06500 RESPI RATORY THERAPY	3, 369, 780	3, 251, 498			0.00000	
66. 00 06600 PHYSI CAL THERAPY	450, 018	3, 784, 118			0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	421, 659	861, 976			0. 000000	
68.00 06800 SPEECH PATHOLOGY	151, 005	237, 785			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	1, 046, 731	3, 141, 681	4, 188, 41		0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	36, 253	55, 860			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 421, 914	7, 678, 842			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 441, 405	4, 629, 332			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 526, 687	16, 155, 913			0.000000	
76.00 03020 ONCOLOGY	3, 654	891, 127			0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	283	674, 993	675, 27	6 0. 623831	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	6, 904	12, 447, 575			0.000000	
91. 00 09100 EMERGENCY	3, 771, 844	28, 151, 974			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	240, 009	1, 640, 471	1, 880, 48	0. 602094	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	1, 158, 497	1, 158, 49	97		101.00
SPECIAL PURPOSE COST CENTERS			-			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	56, 122, 271	191, 728, 690	247, 850, 96	51		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	56, 122, 271	191, 728, 690	247, 850, 96	.1		202.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lieu	ı of Form CMS-2552-	-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared 8/27/2020 4:01 pm	d:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS				30.	00
31.00 03100 INTENSIVE CARE UNIT				31.	00
41.00 04100 SUBPROVI DER – I RF				41.	00
43.00 04300 NURSERY				43.	00
ANCI LLARY SERVI CE COST CENTERS	· ·				
50.00 05000 OPERATI NG ROOM	0. 202790			50.	00
53.00 05300 ANESTHESI OLOGY	0. 041858			53.	00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 123010			54.	00
60. 00 06000 LABORATORY	0. 190224			60.	00
65.00 06500 RESPIRATORY THERAPY	0. 310867			65.	
66.00 06600 PHYSI CAL THERAPY	0. 337177			66.	
67.00 06700 OCCUPATI ONAL THERAPY	0. 373222			67.	
68.00 06800 SPEECH PATHOLOGY	0. 592747			68.	00
69. 00 06900 ELECTROCARDI OLOGY	0. 217468			69.	00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 284857			70.	00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 327158			71.	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 395707			72.	00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 370115			73.	00
76.00 03020 ONCOLOGY	1.013723			76.	00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 623831			76.	97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 234555			90.	00
91.00 09100 EMERGENCY	0. 173594			91.	00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 602094			92.	00
OTHER REIMBURSABLE COST CENTERS	· · · · · ·				
101.00 10100 HOME HEALTH AGENCY				101.	00
SPECIAL PURPOSE COST CENTERS	·				
113.00 11300 I NTEREST EXPENSE				113.	00
200.00 Subtotal (see instructions)				200.	00
201.00 Less Observation Beds				201.	
202.00 Total (see instructions)				202.	
	· ·			1	

	ancial Systems	JOHNSON MEMORI				u of Form CMS-	2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0001	Period:	Worksheet C	
					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	narod
					10 12/31/2019	8/27/2020 4:0	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4.00	5.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	00 ADULTS & PEDIATRICS	7, 907, 659		7, 907, 6	59 0	7, 907, 659	30.00
31.00 0310	DO INTENSIVE CARE UNIT	2, 547, 611		2, 547, 6	11 0	2, 547, 611	31.00
41.00 0410	00 SUBPROVIDER - IRF	154		15	54 0	154	41.00
43.00 0430	DO NURSERY	563, 221		563, 22	21 0	563, 221	43.00
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	DO OPERATING ROOM	6, 689, 216		6, 689, 2	16 0	6, 689, 216	50.00
53.00 0530	DO ANESTHESI OLOGY	215, 183		215, 18	33 0	215, 183	53.00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	6, 413, 833		6, 413, 83	33 0	6, 413, 833	54.00
60.00 0600	DOLABORATORY	7, 200, 179		7, 200, 1	79 0	7, 200, 179	60.00
65.00 0650	DO RESPIRATORY THERAPY	2,058,336	0	2, 058, 33	36 0	2,058,336	65.00
66.00 0660	DO PHYSI CAL THERAPY	1, 427, 653	0	1, 427, 65	53 0	1, 427, 653	66.00
67.00 0670	OO OCCUPATI ONAL THERAPY	479, 081	0	479, 08	31 0	479, 081	67.00
68.00 0680	DO SPEECH PATHOLOGY	230, 454	0	230, 45	54 0	230, 454	68.00
69.00 0690	DO ELECTROCARDI OLOGY	881, 893		881, 89	28, 953	910, 846	69.00
70.00 0700	DO ELECTROENCEPHALOGRAPHY	26, 239		26, 23	39 0	26, 239	70.00
71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 631, 697		3, 631, 69	97 0	3, 631, 697	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENT	3, 193, 649		3, 193, 64	19 0	3, 193, 649	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	7,654,935		7,654,93	35 0	7,654,935	73.00
76.00 0302	20 ONCOLOGY	801, 646		801, 64	105, 414	907,060	76.00
76.97 0769	7 CARDI AC REHABILI TATI ON	421, 258		421, 25	58 0	421, 258	76.97
OUTP	PATIENT SERVICE COST CENTERS						
90.00 0900	DO CLINIC	2, 921, 264		2, 921, 20	64 0	2, 921, 264	90.00
91.00 0910	DO EMERGENCY	5, 541, 781		5, 541, 78	31 0	5, 541, 781	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	1, 132, 225		1, 132, 22	25	1, 132, 225	92.00
OTHE	R REIMBURSABLE COST CENTERS						
101.001010	DO HOME HEALTH AGENCY	1, 144, 231		1, 144, 23	31	1, 144, 231	101.00
SPEC	AL PURPOSE COST CENTERS						
	DO INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	63, 083, 398	0	63, 083, 39	98 134, 367	63, 217, 765	200.00
201.00	Less Observation Beds	1, 132, 225		1, 132, 22	25	1, 132, 225	201.00
202.00	Total (see instructions)	61, 951, 173	C	61, 951, 1	73 134, 367	62, 085, 540	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	Peri od:	Worksheet C	
				From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	narod
				10 12/31/2019	8/27/2020 4:0	
		Ti tl	e XIX	Hospi tal	Cost	
	Charges					
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
		·	+ col. 7)	Rati o	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	10, 710, 704		10, 710, 7	04		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 297, 334		1, 297, 3	34		31.00
41. 00 04100 SUBPROVI DER – I RF	0			0		41.00
43. 00 04300 NURSERY	2,074,424		2, 074, 4	24		43.00
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	6, 276, 411	26, 709, 590			0.000000	
53. 00 05300 ANESTHESI OLOGY	832, 328	4, 308, 492			0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 204, 270	45, 936, 531			0.000000	
60. 00 06000 LABORATORY	7, 838, 654	30, 012, 435			0.000000	
65. 00 06500 RESPI RATORY THERAPY	3, 369, 780	3, 251, 498			0.000000	
66. 00 06600 PHYSI CAL THERAPY	450, 018	3, 784, 118			0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	421, 659	861, 976			0.000000	
68.00 06800 SPEECH PATHOLOGY	151, 005	237, 785			0.000000	
69. 00 06900 ELECTROCARDI OLOGY	1, 046, 731	3, 141, 681			0.000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	36, 253	55, 860			0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 421, 914	7, 678, 842			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 441, 405	4, 629, 332			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 526, 687	16, 155, 913			0.000000	
76.00 03020 ONCOLOGY	3, 654	891, 127			0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	283	674, 993	675, 2	0. 623831	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · · ·		1	1		
90. 00 09000 CLINIC	6, 904	12, 447, 575			0.00000	
91.00 09100 EMERGENCY	3, 771, 844	28, 151, 974			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	240, 009	1, 640, 471	1, 880, 4	0. 602094	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS	1					
101.00 10100 HOME HEALTH AGENCY	0	1, 158, 497	1, 158, 4	77		101.00
SPECIAL PURPOSE COST CENTERS			1			1
113.00 11300 INTEREST EXPENSE	F (100 F)	101 700				113.00
200.00 Subtotal (see instructions)	56, 122, 271	191, 728, 690	247, 850, 9	DT .		200.00
201.00 Less Observation Beds	F(100 071	404 700 (00	0.47.050.0			201.00
202.00 Total (see instructions)	56, 122, 271	191, 728, 690	247, 850, 9	ווס		202.00

Health Financial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lieu	J of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 8/27/2020 4:01 pm
		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 SUBPROVI DER – I RF				41.00
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE 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 PATIENTS	0.000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	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				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 HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost	:	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		-			
30. 00 ADULTS & PEDIATRICS	475, 352		475, 35			1
31.00 INTENSIVE CARE UNIT	158, 513		158, 51	3 503	315.14	31.00
41.00 SUBPROVIDER - IRF	1	0		1 0	0.00	
43.00 NURSERY	3, 816		3, 81	6 736	5. 18	43.00
200.00 Total (lines 30 through 199)	637, 682		637, 68	32 7, 420		200.00
Cost Center Description	Inpati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 122					30.00
31.00 INTENSIVE CARE UNIT	241	75, 949	1			31.00
41. 00 SUBPROVIDER - IRF	0	0				41.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	2, 363	239, 152				200.00

Health Financial Systems	JOHNSON MEMORI				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2019	Worksheet D Part	
				To 12/31/2019	Date/Time Pre	nared.
				10 12/01/2017	8/27/2020 4:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	975, 496					
53. 00 05300 ANESTHESI OLOGY	29, 381	5, 140, 820				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	700, 197					
60. 00 06000 LABORATORY	406, 562	37, 851, 089			37, 994	
65. 00 06500 RESPI RATORY THERAPY	99, 839				19, 565	65.00
66. 00 06600 PHYSI CAL THERAPY	52, 117				2, 654	66.00
67.00 06700 OCCUPATI ONAL THERAPY	17, 154				2, 691	
68.00 06800 SPEECH PATHOLOGY	7, 173				1, 551	
69. 00 06900 ELECTROCARDI OLOGY	127, 337				28, 190	
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 080				624	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	101, 761	11, 100, 756			11, 137	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	22, 763				3, 951	
73.00 07300 DRUGS CHARGED TO PATIENTS	101, 180	20, 682, 600			9, 030	
76.00 03020 ONCOLOGY	36, 488				0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	19, 316	675, 276	0. 02860	5 0	0	76.9
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	137, 908					90.00
91. 00 09100 EMERGENCY	227, 997					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	68, 061	1, 880, 480	0. 03619	3 240, 009		
200.00 Total (lines 50 through 199)	3, 133, 810	232, 610, 002		17, 296, 443	228, 218	200.00

Health Financial Systems	JOHNSON MEMOR	I AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	Period: From 01/01/2019 Fo 12/31/2019	Date/Time Pre 8/27/2020 4:0	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C) (0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	c c		0 0	0	31.00
41.00 04100 SUBPROVI DER – I RF	0	c c		0 0	0	41.00
43. 00 04300 NURSERY	0	l c		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	l c		0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C	6, 18	0.00	2, 122	30.00
31.00 03100 INTENSIVE CARE UNIT		l c	503	0.00	241	31.00
41. 00 04100 SUBPROVI DER – I RF	0	l c			0	
43. 00 04300 NURSERY			736	0.00	0	43.00
200.00 Total (lines 30 through 199)			7,420		2, 363	200.00
Cost Center Description	I npati ent	-	.,	-	_,	
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
41. 00 04100 SUBPROVI DER – I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	1 0	I				

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-0001	Period: From 01/01/2019	Worksheet D Part IV	
				To 12/31/2019	Date/Time Pre	
			e XVIII	Hospi tal	8/27/2020 4:0 PPS	I pm
Cost Center Description	Non Physician		Nursing	Allied Health		
cost center bescription	Anesthetist	School	School	Post-Stepdown	Arried field th	
	Cost	Post-Stepdown		Adjustments		
	0001	Adjustments		riaj do tiliorreo		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	(D	0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(D	0 0	0	54.00
60. 00 06000 LABORATORY	0	0	D	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	D	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	D	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C	D	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C	D	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C	D	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C	D	0 0	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	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	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	(ע	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1	0 0	0	90.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0	(0 0	0	90.00
	0	l l		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Total (lines 50 through 199)	0			0	0	92.00 200.00
200.00 TOLAI (TTHES SO LITIOUGH 199)	1 0		4	U U	0	1200.00

Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	-	-				
50. 00 05000 OPERATING ROOM	0	0		0 32, 986, 001		
53. 00 05300 ANESTHESI OLOGY	0	0		5, 140, 820		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 52, 140, 801		
60. 00 06000 LABORATORY	0	0		0 37, 851, 089		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 6, 621, 278		65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 4, 234, 136		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 283, 635		
68.00 06800 SPEECH PATHOLOGY	0	0		0 388, 790		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 4, 188, 412		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 92, 113		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 11, 100, 756		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 8, 070, 737		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 20, 682, 600		
76.00 03020 ONCOLOGY	0	0		0 894, 781		
76. 97 07697 CARDIAC REHABILITATION	0	0		0 675, 276	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS	1	-		1	r	
90. 00 09000 CLINIC	0	0		0 12, 454, 479		
91.00 09100 EMERGENCY	0	0		0 31, 923, 818		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 880, 480		
200.00 Total (lines 50 through 199)	0	0		0 232, 610, 002		200.00

67.00 06700 OCCUPATI ONAL THERAPY 0.000000 201,325 0 3,112 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 84,080 0 6,057 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 927,252 0 1,184,488 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 18,670 0 18,360 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,484,488 0 1,328,332 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 1,400,962 0 1,124,026 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,845,773 0 5,826,776 0 73.00 76.00 76.07 03020 ONCOLOGY 0.000000 0 0 103,715 0 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 138,677 0 76.00	Health Financial Systems	JOHNSON MEMORIA			In Lie	u of Form CMS-2	2552-10
Interview To 12/31/2019 Date/Time Prepared: 8/27/2020 4:01 pm Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges Inpatient Program Charges Outpatient Program Charges Outp		RVICE OTHER PASS	Provider C				
And Lillary Service cost Center Description Outpati ent Rati o of Cost to Charges (col. 6 ÷ col. 7) Inpati ent Program Charges Inpati ent Program Charges Dutpati ent Program Charges Outpati ent Program Charges O	THROUGH COSTS						narod
Cost Center Description Outpatient Ratio of Cost to Charges Inpatient Program Charges Inpatient Program Costs (col. 8 x col. 10) Hospital Uutpatient Program Charges Hospital Program Pass-Through Costs (col. 8 x col. 10) Hospital Program Pass-Through Costs (col. 8 x col. 10) Hospital Program Pass-Through Costs (col. 9 x col. 10) Hospital Program Pass-Through Costs (col. 9 x col. 12) Hospital Program Pass-Through Costs (col. 9 x col. 12) 50. 00 05000 OPERATING ROOM 0.000000 1855,260 0 6,498,035 0 50.00 53. 00 05400 RADIOLOGY-DI AGNOSTI C 0.000000 243,060 0 702,120 653.00 66. 00 06600 RESPI RATORY THERAPY 0.000000 2,577,590 0 10,323,436 0 54.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 2,577,590 0 10,323,436 0 66.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 2,577,590 0 10,323,436 0 67.00 66. 00 06600 PHYSI CAL THERAPY 0.000000 2,15,578 0 5,256 0 66.00 69. 00 06000 ELECTROCARDI 0LOGY <t< td=""><td></td><td></td><td></td><td></td><td>10 12/31/2019</td><td></td><td></td></t<>					10 12/31/2019		
Ratio of Cost to Charges Program Charges Program Pass-Through Costs (col. 6 x col. 10) Program Charges Program Pass-Through Costs (col. 6 x col. 10) Program Charges			Title	XVIII	Hospi tal		
to Charges (col. 7) Charges (col. 7) Pass-Through Costs (col. 8 Charges X col. 10) Pass-Through Costs (col. 9 ANCI LLARY SERVICE COST CENTERS 0 11.00 12.00 13.00 50.00 05000 (PERATI NG ROOM 0.000000 1,855,260 0 6,498,035 0 50.00 53.00 05300 (ANESTHESI OLOGY 0.000000 2,43,060 0 702,120 0 53.00 54.00 06400 (ADI OLOGY-DI AGNOSTI C 0.000000 2,507,590 0 10,323,436 0 54.00 60.00 06500 (RESPI RATORY THERAPY 0.000000 2,507,590 0 2,717,098 0 60.00 65.00 06500 (RESPI RATORY THERAPY 0.000000 211,325 0 3,112 0 67.00 66.00 06000 ELECTROCARDI OLOGY 0.000000 211,325 0 3,112 0 67.00 69.00 06000 ELECTROCARDI OLOGY 0.000000 217,325 0 1,184,488 0 69.00 70.00 07100 ELECTROCARDI OLOGY 0.0000	Cost Center Description	Outpatient	I npati ent	Inpati ent	Outpati ent	Outpati ent	
ANCILLARY SERVICE COST CENTERS Costs (col. 8 col. 7) Costs (col. 9 x col. 10) Costs (col. 9 x col. 12) 50.00 05000 0PERATING ROM 0.000000 1855,260 0 6.498,035 0 50.00 53.00 05300 ANSTHESIOLOGY 0.000000 243,060 0 70.2120 0 53.00 54.00 05400 RADIOLOGY 0.000000 2,507,590 0 10,323,436 0 54.00 66.00 06000 LABORATORY 0.000000 3,537,252 0 2,717,098 66.00 65.00 06500 RESPI RATORY THERAPY 0.000000 215,578 0 5,256 66.00 67.00 06700 OCLPATI ONAL THERAPY 0.000000 201,325 0 3,112 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 927,252 0 1,184,488 69.00 69.00 70.00 OT000 ELECTROCARDI OLOGY 0.000000 1,214,026 72.00 73.00 71.00 OT100		Ratio of Cost	Program	Program	Program	Program	
Image: col. 7) x col. 10) x col. 12) 9.00 10.00 11.00 12.00 13.00 4.00 05000 OPERATI NG ROOM 0.000000 1,855,260 0 6,498,035 0 50.00 53.00 05300 ANESTHESI OLOGY 0.000000 243,060 0 702,120 0 53.00 54.00 05400 RADIOLGY-DI AGNOSTI C 0.000000 2,507,590 0 10,323,436 0 54.00 60.00 06000 LABORATORY 0.000000 3,537,252 0 2,717,098 66.00 65.00 06500 RESPI RATORY THERAPY 0.000000 215,578 0 5,256 0 66.00 66.00 06600 PHY OLOGY 0.000000 201,325 0 3,112 0 67.00 67.00 6,057 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 1,214,848 0 1,328,332 0 71.00 70.00 OTOOL LASURGED TO PATI ENTS		to Charges	Charges	Pass-Through	Charges	Pass-Through	
9.00 10.00 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 50.00 OPERATI NG ROOM 0.000000 1,855,260 0 6,498,035 0 50.00 53.00 OS300 ANESTHESI OLOGY 0.000000 243,060 0 702,120 0 53.00 60.00 O6400 RADI OLOGY-DI AGNOSTI C 0.000000 2,507,590 0 10.323,436 0 54.00 65.00 O6500 RESPI RATORY THERAPY 0.000000 3,537,252 0 2,717,098 0 60.00 66.00 O6600 PHYSI CAL THERAPY 0.000000 215,578 0 5,256 0 66.00 67.00 O6700 OCUPATI ONAL THERAPY 0.000000 215,578 0 3,112 0 67.00 68.00 O6800 SPEECH PATHOLOGY 0.000000 24,257 0 1,184,488 0 69.00 69.00 O6900 ELECTROCARDI OLOGY 0.000000 1,214,848 0 1,328,332 0 71.00 0.000		(col. 6 ÷		Costs (col.	8	Costs (col. 9	
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.000000 1,855,260 0 6,498,035 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 243,060 0 702,120 0 53.00 64.00 06400 RADI OLOGY-DI AGNOSTI C 0.000000 2,507,590 0 10,323,436 0 60.00 65.00 06500 RESPI RATORY 0.000000 3,537,252 0 2,717,098 0 60.00 66.00 06600 PHYSI CAL THERAPY 0.000000 215,578 0 5,256 0 66.00 67.00 0CCUPATI ONAL THERAPY 0.000000 201,325 0 3,112 0 67.00 0 069000 ELECTROCARDI OLOGY 0.000000 84,080 0 6,057 0 68.00 69.00 069000 ELECTROCARDI OLOGY 0.000000 18,670 0 18,360 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 1,444,488				x col. 10)			
50.00 05000 OPERATING ROOM 0.000000 1,855,260 0 6,498,035 0 50.00 53.00 OS300 ANESTHESI OLOGY 0.000000 243,060 0 702,120 0 53.00 54.00 OS400 RADI OLOGY-DI AGNOSTI C 0.000000 2,507,590 0 10,323,436 0 60.00 60.00 O6000 LABORATORY 0.000000 3,537,252 0 2,717,098 0 60.00 65.00 O6500 RESPI RATORY THERAPY 0.000000 215,578 0 5,256 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 201,325 0 3,112 0 67.00 68.00 O6800 SPEECH PATHOLOGY 0.000000 84,080 0 6,057 0 68.00 69.00 OT000 ELECTROENCEPHALOGRAPHY 0.000000 18,670 1.84,488 0 7.22.00 72.00 70.00 OT000 ELECTROENCEPHALOGRAPHY 0.000000 1,		9.00	10.00	11.00	12.00	13.00	
53.00 05300 ANESTHESI OLOGY 0.000000 243,060 0 702,120 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2,507,590 0 10,323,436 0 54.00 60.00 06000 LABORATORY 0.000000 3,537,252 0 2,717,098 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 1,297,512 0 67,07 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 201,325 0 3,112 0 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 201,325 0 3,112 0 67.00 68.00 06800 PEECH PATHOLOGY 0.000000 927,252 0 1,184,488 0 70.00 70.00 70.00 07000 ELECTROCARDI OLOGY+IDANCRAPHY 0.000000 1,214,848 0 1,328,332 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,400,962 0 1,124,026 0 72.00		· · · · ·					
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2,507,590 0 10,323,436 0 54.00 60.00 06000 LABORATORY 0.000000 3,537,252 0 2,717,098 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 1,297,512 0 697,372 0 65.00 66.00 06400 PHYSI CAL THERAPY 0.000000 215,578 0 5,256 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 201,325 0 3,112 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 24,080 0 6,057 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 927,252 0 1,184,488 0 69.00 70.00 07000 ELECTROCARDI OLOGY 0.000000 1,214,848 0 1,328,332 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,445,773 0 5.826,776 0 73.00 73.02 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
60.00 06000 LABORATORY 0.000000 3, 537, 252 0 2, 717, 098 0 60.00 65.00 06500 RESPI RATORY THERAPY 0.000000 1, 297, 512 0 697, 372 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 215, 578 0 5, 256 0 66.00 67.00 0CCUPATI ONAL THERAPY 0.000000 201, 325 0 3, 112 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 84, 080 0 6, 057 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 927, 252 0 1, 184, 488 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1, 214, 848 0 1, 328, 332 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 1, 400, 962 1, 124, 026 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 103, 715 0 76.00							
65.00 06500 RESPI RATORY THERAPY 0.000000 1,297,512 0 697,372 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 215,578 0 5,256 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 201,325 0 3,112 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 84,080 0 6.057 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 927,252 0 1,184,488 0 69.00 71.00 07100 MEDL CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 1,400,962 0 1,328,332 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 1,445,773 0 5,826,776 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 103,715 0 76.00 76.00 03202 ONCLOGY 0.000000 0 0 0 03,008,858 0 90.00 0							
66.00 06600 PHYSI CAL THERAPY 0.000000 215,578 0 5,256 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 0.000000 201,325 0 3,112 0 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 84,080 0 6,057 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 927,252 0 1,184,488 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 18,670 0 18,360 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,214,848 0 1,328,332 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 1,440,962 0 1,328,332 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,845,773 0 5,826,776 0 73.00 76.97 ORAPI AC REHABI LI TATI ON <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
67.00 06700 OCCUPATI ONAL THERAPY 0.000000 201,325 0 3,112 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 84,080 0 6,057 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 927,252 0 1,184,488 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 18,670 0 18,360 0 70.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,484,88 0 1,328,332 0 71.00 72.00 07300 DRUGS CHARGED TO PATI ENT 0.000000 1,440,962 0 1,124,026 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,845,773 0 5,826,776 0 73.00 76.00 03020 ONCLOGY 0.000000 0 0 138,677 0 76.00 76.97 O477 CARDI AC REHABI LI TATI ON 0.000000 0 0 138,677 0 76.00 76.9							
68.00 06800 SPEECH PATHOLOGY 0.000000 84,080 0 6,057 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 927,252 0 1,184,488 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 18,670 0 18,360 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,214,848 0 1,328,332 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 1,400,962 0 1,124,026 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,845,773 0 5,826,776 0 73.00 76.07 03020 ONCOLOGY 0.000000 0 0 103,715 0 76.00 0 00000 0 0 0 0.000000 0 0 138,677 0 76.00							66.00
69.00 06900 ELECTROCARDI OLOGY 0.000000 927,252 0 1,184,488 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 18,670 0 18,360 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,214,848 0 1,328,332 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 1,400,962 0 1,124,026 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,845,773 0 5,826,776 0 73.00 76.00 03020 ONCOLOGY 0.000000 0 0 103,715 0 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 138,677 0 76.97 0010 09000 CLI NI C 0.000000 5,606 0 3,008,858 90.00 91.00 09100 EMERGENCY 0.000000 1,701,666 4,721,944 91.00 92.00 09200 OB			201, 325			0	67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 18,670 0 18,360 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1,214,848 0 1,328,332 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 1,400,962 0 1,124,026 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,845,773 0 5,826,776 0 73.00 76.00 03020 ONCOLOGY 0.000000 0 0 103,715 0 76.00 76.97 ORADI AC REHABI LI TATI ON 0.000000 0 0 138,677 0 76.97 00TPATI ENT SERVI CE COST CENTERS 0.000000 0 0 3,008,858 90.00 90.00 91.00 09100 EMERGENCY 0.000000 1,701,666 4,721,944 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 240,009 0 <td></td> <td></td> <td>84, 080</td> <td></td> <td>0 6, 057</td> <td>0</td> <td></td>			84, 080		0 6, 057	0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 1, 214, 848 0 1, 328, 332 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 1, 400, 962 0 1, 124, 026 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1, 845, 773 0 5, 826, 776 0 73.00 76.00 03020 ONCOLOGY 0.000000 0 0 103, 715 0 76.00 76.00 07697 CARDI AC REHABI LI TATI ON 0.000000 0 0 138, 677 0 90.00 00TPATI ENT SERVI CE COST CENTERS 0.000000 5, 606 0 3, 008, 858 90.00 90.00 09000 CLI NI C 0.000000 1, 701, 666 4, 721, 944 0 91.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 240, 009 475, 059 0 92.00			927, 252		0 1, 184, 488	0	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 0.000000 1,400,962 0 1,124,026 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 1,845,773 0 5,826,776 0 73.00 76.00 03020 ONCOLOGY 0.000000 0 0 103,715 0 76.00 76.97 CARDI AC REHABI LI TATI ON 0.000000 0 0 138,677 0 76.97 0UTPATI ENT SERVI CE COST CENTERS 0.000000 5,606 0 3,008,858 0 90.00 91.00 09100 EMERGENCY 0.000000 1,701,666 0 4,721,944 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 240,009 0 475,059 0 92.00		0. 000000	18, 670		0 18, 360	0	70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1,845,773 0 5,826,776 0 73.00 76.00 03020 ONCOLOGY 0.000000 0 0 103,715 0 76.00 76.97 OADATION CARDIAC REHABILITATION 0.000000 0 0 138,677 0 76.00 76.97 OADATIENT SERVICE COST CENTERS 0.000000 0 0 138,677 0 76.97 90.00 09000 CLINIC 0.000000 5,606 0 3,008,858 0 90.00 91.00 09100 EMERGENCY 0.000000 1,701,666 0 4,721,944 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.000000 240,009 0 475,059 0 92.00							71.00
76.00 03020 ONCOLOGY 0.000000 0 0 103,715 0 76.00 76.97 07697 CARDI AC_REHABI LI TATI ON 0.000000 0 0 138,677 0 76.97 0UTPATI ENT SERVICE COST CENTERS 0.000000 5,606 0 3,008,858 0 90.00 91.00 09100 EMERGENCY 0.000000 1,701,666 0 4,721,944 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 240,009 0 475,059 0 92.00							
76. 97 07697 CARDI AC_REHABI LI TATI ON 0.000000 0 138, 677 0 76. 97 OUTPATI ENT_SERVICE_COST_CENTERS 0.000000 5, 606 0 3, 008, 858 0 90. 00 90. 00 09100 EMERGENCY 0.000000 1, 701, 666 0 4, 721, 944 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 240, 009 0 475, 059 0 92. 00			1, 845, 773		0 5, 826, 776	0	73.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 5,606 0 3,008,858 0 90.00 91.00 09100 EMERGENCY 0.000000 1,701,666 0 4,721,944 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 240,009 0 475,059 0 92.00	76.00 03020 ONCOLOGY	0. 000000	0		0 103, 715	0	76.00
90. 00 09000 CLINIC 0.00000 5,606 0 3,008,858 0 90.00 91. 00 09100 EMERGENCY 0.000000 1,701,666 0 4,721,944 0 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 240,009 0 475,059 0 92.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 138, 677	0	76.97
91.00 09100 EMERGENCY 0.000000 1,701,666 0 4,721,944 0 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 240,009 0 475,059 0 92.00					-		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 000000 240, 009 0 475, 059 0 92. 00		0. 000000	5, 606		0 3, 008, 858	0	90.00
							91.00
		0. 000000					92.00
200.00 10tal (11nes 50 through 199) 17,296,443 0 38,882,721 0 200.00	200.00 Total (lines 50 through 199)		17, 296, 443		0 38, 882, 721	0	200.00

Health Financial Systems	JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	8/27/2020 4:0	
		Title	× XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 202790			0 0	1, 317, 737	
53. 00 05300 ANESTHESI OLOGY	0. 041858			0 0	29, 389	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 123010			0 0	1, 269, 886	
60. 00 06000 LABORATORY	0. 190224			0 0	516, 857	
65. 00 06500 RESPI RATORY THERAPY	0. 310867	697, 372		0 0	216, 790	
66. 00 06600 PHYSI CAL THERAPY	0. 337177			0 0	1, 772	
67.00 06700 OCCUPATI ONAL THERAPY	0. 373222			0 0	1, 161	
68.00 06800 SPEECH PATHOLOGY	0. 592747			0 0	3, 590	•
69. 00 06900 ELECTROCARDI OLOGY	0. 210555			0 0	249, 400	•
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 284857			0 0	5, 230	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 327158			0 0	434, 574	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 395707			0 0	444, 785	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 370115			0 0	2, 156, 577	•
76.00 03020 ONCOLOGY	0. 895913	103, 715		0 0	92, 920	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 623831	138, 677		0 0	86, 511	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 234555		1, 51	8 0	705, 743	
91. 00 09100 EMERGENCY	0. 173594	4, 721, 944		0 0	819, 701	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 602094	475, 059	79	02 0	286, 030	92.00
200.00 Subtotal (see instructions)		38, 882, 721	2, 31	0 0	8, 638, 653	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		38, 882, 721	2, 31	0 0	8, 638, 653	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0001 Period: From 01/01/2019 To 12/31/2019 Worksheet D Bate/Time Prepared: 02/202 4:01 pm Cost Center Description Cost S Cost Reinbursed Services Services Subject To Ded. & Coins. (see Inst.) Cost Reinbursed Services Subject To Ded. & Coins. (see Inst.) Period: To 12/31/2019 Period: Date/Time Prepared: 02/202 4:01 pm ANCILLARY SERVICE COST CENTERS Cost Cost Reinbursed Services Subject To Ded. & Coins. (see Inst.) Cost Services Subject To Ded. & Coins. (see Inst.) Source Source 50.00 GSOOQ OPERATING ROOM S3.00 0 0 0 Source Source 50.00 GSOOQ RESPIRATING ROOM S3.00 0 0 0 Source Source<	Health Financial Systems	JOHNSON MEMORI	AL HOSPI TAL		In Lieu	u of Form CMS-	2552-10
Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 50.00 05000 OPERATING ROOM 05000 OPERATING ROOM 53.00 0 0 0 50.00 05000 OPERATING ROOM 05000 OPERATING ROOM 53.00 0 0 0 50.00 05000 OPERATING ROOM 053.00 0 0 0 50.00 50.00 05000 OPERATING ROOM 054.00 0 0 0 53.00 50.00 05000 OPERATING ROOM 050 OPERATING ROOM 060 OPERATING ROOM 00 OPERA	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0001	From 01/01/2019	Part V Date/Time Pro	
Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 0.00 05000 (DERATING ROOM 0 0 50.00 05000 (DERATING ROOM 0 0 51.00 05000 (DEGRATORY 0 0 60.00 0 0 0 54.00 61.00 0 0 0 0 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 66.00 66.00 60.00 0 0 0 0 66.00 67.00 60.00 06600 PHYSICAL THERAPY 0 0 0 67.00 70.00 0 0 0 0 72.00 72.00			Title	XVIII	Hospi tal	PPS	
Reimbursed Subject To Ded. & Coins. Reimbursed Subject To Ded. & Coins. Services (see inst.) 50.00 05000 (PPERATING ROOM 0 0 0 50.00		Cos	sts				
ANCI LLARY SERVICE COST CENTERS Services Subject To Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) 50.00 60.00 60.00 60.00 60.00 66.00 66.00 66.00 66.00 67.00 68.00 66.00 67.00 68.00 66.00 67.00 69.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00	Cost Center Description						
Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) 6.00 7.00 50.00 05000 OPERATING ROOM 0 0 50.00 53.00 05300 ANESTHESIOLOGY 0 0 53.00 54.00 05400 RADIOLOGY-DI ARONSTIC 0 0 53.00 66.00 0 0 0 0 54.00 66.00 06000 LABORATORY 0 0 0 66.00 66.00 06600 PHYSICAL THERAPY 0 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 66.00 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 67.00 67.00 69.00 06900 ELECTROCARDI OLOGY 0 0 71.00							
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Image: state inst. (see inst.) (see instst.) (see insts.) (see inst.)<							
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73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 03020 ONCOLOGY 0 0 76.00 76.07 07697 CARDI AC_REHABILITATION 0 0 76.97 0UTPATIENT SERVICE COST CENTERS 0 0 0 76.97 90.00 09100 CLINIC 356 0 90.00 91.00 09200 DBSERVATION BEDS (NON-DI STINCT PART) 477 0 91.00 92.00 092000 BSERVATION SEDS (NON-DI STINCT PART) 477 0 92.00 200.00 Subtotal (see instructions) 833 0 200.00 201.00 201.00 Urarges 0 0 0 201.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
76.00 03020 ONCOLOGY 0 0 76.00 76.00 76.00 76.00 76.97 76.01 76.01 76.00 76.97 76.01 76.01 76.00 76.97 76.01 76.01 76.00 76.97 76.01 76.01 76.97 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 92.0	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 76. 97 OUTPATI ENT SERVICE COST CENTERS 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 92. 00 0 0 0 91. 00 92. 00 92.00 08SERVATI ON BEDS (NON-DI STI NCT PART) 477 0 92. 00 92.00<	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 356 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 477 0 92.00 200.00 Subtotal (see instructions) 833 0 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 201.00	76.00 03020 ONCOLOGY	0	0				76.00
90.00 09000 CLINIC 356 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 477 0 92.00 200.00 Subtotal (see instructions) 833 0 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 477 0 92.00 200.00 Subtotal (see instructions) 833 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 201.00	OUTPATIENT SERVICE COST CENTERS						
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 477 0 92.00 200.00 Subtotal (see instructions) 833 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00	90. 00 09000 CLINIC	356	0				90.00
200.00Subtotal (see instructions)8330200.00201.00Less PBP Clinic Lab. Services-Program00201.000nl y Charges0000	91.00 09100 EMERGENCY	0	0				91.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 0	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	477	0				92.00
Only Charges	200.00 Subtotal (see instructions)	833	0				200.00
Only Charges	201.00 Less PBP Clinic Lab. Services-Program	0					201.00
202.00 Net Charges (line 200 - line 201) 833 0 202.00							
	202.00 Net Charges (line 200 - line 201)	833	0				202.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 8/27/2020 4:0	pare
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I – ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			6, 181	1.
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs	6, 181 0	2. 3.
00	do not complete this line.	5, 5, 5,	rivate room aays,	0	
00	Semi-private room days (excluding swing-bed and observation b		01 -6 +6	5, 296	4.
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oni days) through becenib	er 31 of the cost	0	5.
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roc	m days) through Decembe	r 31 of the cost	0	7
00	reporting period	in days) through becembe		0	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	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 t	to the Program (excludin	a swing-bed and	2, 122	9
00	newborn days) (see instructions)	5		2, 122	ĺ
. 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 instruc Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)			
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
~~	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT		<u>C 11</u>	0.00	1 4 7
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31	or the cost	0.00	' /
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	as through December 31 o	f the cost	0.00	10
. 00	reporting period	ss through becember 51 0	i the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	ns)		7, 907, 659	21
	Swing-bed cost applicable to SNF type services through Decemb	<i>,</i>	ting period (line		
00	5 x line 17)	- 01 - E + b +			
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost report	ng period (line a	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reportin	a poriod (line 9	0	25
. 00	x line 20)	ST OF the cost reporting		0	25
. 00	Total swing-bed cost (see instructions)	<i></i>		0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		7,907,659	27
. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges)			0	
. 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)	. True 20)		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	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)	no 31)		0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	7, 907, 659	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
	Adjusted general inpatient routine service cost per diem (see	-		1, 279. 35	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		2, 714, 781 0	
. 00					

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	JOHNSON MEMORIA	Provider C	CN: 15-0001	Period:	u of Form CMS-2 Worksheet D-1		
					rom 01/01/2019 o 12/31/2019	Date/Time Pre 8/27/2020 4:0		
			Title	XVIII	Hospi tal	PPS		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
2.00	NURSERY (title V & XIX only)	0	0	0.00	0 0	0	42.0	
43.00 44.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT	2, 547, 611	503	5, 064. 83	3 241	1, 220, 624	44. C	
5.00 6.00 7.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						45.0 46.0 47.0	
	Cost Center Description	·		•		1 00		
8.00	Program inpatient ancillary service cost (Wk	st D_3 col 3	line 200)			1.00 4,251,903	48.0	
9.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		8, 187, 308		
0.00	Pass through costs applicable to Program inp.	atient routine	services (fro	n Wkst. D, sum	of Parts I and	239, 152	50.0	
51.00	Pass through costs applicable to Program inpland $\rm IV)$		y services (f	rom Wkst. D, s	um of Parts II	228, 218		
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line	ding capital re	lated, non-ph	ysician anesth	etist, and	467, 370 7, 719, 938		
4.00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges					0	54.0	
54.00	Target amount per discharge					0.00		
6.00	Target amount (line 54 x line 55)					0		
7.00								
 8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 							58. (59. (
0. 00 1. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less that	s 55, 59 or 60 n expected cost	enter the les	ser of 50% of		0. 00 0		
52.00 53.00								
4.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.0	
5.00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.0	
6. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.0	
57.00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67.0	
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)				rting period		68.0	
59.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY		0	1	
20.00 21.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	,					70.0	
2.00	Program routine service cost (line 9 x line			2)			72.0	
3.00	Medically necessary private room cost application						73.0	
4.00 5.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•			art II, column		74. (75. (
6.00	Per diem capital-related costs (line 75 ÷ li						76.0	
7.00 8.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:						77. 78.	
9.00	Aggregate charges to beneficiaries for excess		rovi der recor	ds)			79.	
0.00	Total Program routine service costs for comp	• •			us line 79)		80.	
1.00	Inpatient routine service cost per diem limi		、 、				81.	
2.00	Inpatient routine service cost limitation (I		· .				82.	
33.00 34.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		5)				83. 84.	
35.00	Utilization review - physician compensation		ns)				85.	
36.00	Total Program inpatient operating costs (sum						86.	
	PART IV - COMPUTATION OF OBSERVATION BED PASS							
	LIGTAL OPSORVATION had dave (soo instructions)	1				885	87.0	
37.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			1, 279. 35		

Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	475, 352	7, 907, 659	0. 06011	3 1, 132, 225	68, 061	90.00
91.00 Nursing School cost	0	7, 907, 659	0.00000	0 1, 132, 225	0	91.00
92.00 Allied health cost	0	7,907,659	0.00000	0 1, 132, 225	0	92.00
93.00 All other Medical Education	0	7, 907, 659	0.00000	0 1, 132, 225	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0001	Period: From 01/01/2019	Worksheet D-1	
		Title XIX	To 12/31/2019 Hospi tal	Date/Time Pre 8/27/2020 4:0 Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS			1.00	
00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		6, 181	1.
00 00	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day		rivate room days,	6, 181 0	
00	do not complete this line.			F 20/	
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		er 31 of the cost	5, 296 0	
00	Total swing-bed SNF type inpatient days (including private roo 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 room reporting period	m days) through Decembe	r 31 of the cost	0	7
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	31 of the cost	0	8
00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excludin	g swing-bed and	134	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private	room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI> through December 31 of the cost reporting period		te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ve			0	13
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			736 42	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of	the cost	0.00	20
	reporting period Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ting period (line	7, 907, 659 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reportin	g period (line 8	0	25
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((lino 21 minus lino 26)		0 7, 907, 659	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	· · · ·			
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed c	harges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0. 000000	31
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)		ati ana)	0.00	
	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lir	, ,		0.00 0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost d	ifferential (line	-	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 070 05	1
				1, 279. 35	38
	Adjusted general inpatient routine service cost per diem (see				
. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	38)		171, 433	39

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	JOHNSON MEMORI	Provider C		eri od:	u of Form CMS-2 Worksheet D-1	
					rom 01/01/2019 o 12/31/2019	Date/Time Pre	
			Ti †I	e XIX	Hospi tal	8/27/2020 4:0 Cost) pm
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only)	563, 221	736				42.
	Intensive Care Type Inpatient Hospital Units	r		[1		
. 00	INTENSIVE CARE UNIT	2, 547, 611	503	5, 064. 83	0	0	
. 00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T						44
. 00	SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						40
. 00	Cost Center Description						17
						1.00	
. 00	Program inpatient ancillary service cost (Wk					127, 881	
. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructio	ons)		331, 455	49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing	sorvicos (fro	wkst D sum	of Parts L and	0	50
. 00	(111)		Services (IIU	II WKSL. D, SUIII		. 0	1 30
. 00	Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst. D. s	um of Parts II	0	51
-	and IV)		, (··			-	
. 00	Total Program excludable cost (sum of lines					0	1
. 00	Total Program inpatient operating cost exclu	5 1	lated, non-phy	ysician anesth	etist, and	0	53
	medical education costs (line 49 minus line	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges					0	54
	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operat	0	57				
. 00	Bonus payment (see instructions)		0				
. 00	Lesser of lines 53/54 or 55 from the cost re	mpounded by the	0.00	59			
. 00	market basket	cast report up	dated by the	markat backat		0.00	60
. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	
. 00	which operating costs (line 53) are less that					l U	
	amount (line 56), otherwise enter zero (see				<u>g</u>		
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	icti ons)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Doco	mbor 21 of th	a cost reporti	na pari ad (Saa	0	64
. 00	instructions)(title XVIII only)	ts through bece		e cost reportin	ng period (see	0	04
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the (cost reportina	period (See	0	65
	instructions)(title XVIII only)			1 5			
b. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66
	CAH (see instructions)			C 11			
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 (of the cost re	porting period	0	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost reno	rting period	0	68
. 00	(line 13 x line 20)			the cost repo	r tring per rou	,	
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N						
0.00	Skilled nursing facility/other nursing facil						70
. 00 . 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ line	2)			71
. 00	Medically necessary private room cost applic		line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv	0		,			74
. 00	Capital-related cost allocated to inpatient				art II, column		75
	26, line 45)					l	
. 00	Per diem capital-related costs (line 75 ÷ li					1	76
. 00	Program capital -related costs (line 9 x line					1	77
00 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider rocor	de)			78
00	Total Program routine service costs for comp	• •			us line 79)		80
00	Inpatient routine service cost per diem limi			(o .o min		l	81
. 00	Inpatient routine service cost limitation (I)			l	82
. 00	Reasonable inpatient routine service costs (see instruction				l	83
. 00	Program inpatient ancillary services (see in						84
. 00	Utilization review - physician compensation					1	85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
~~~	PART IV - COMPUTATION OF OBSERVATION BED PAS: Total observation bed days (see instructions					885	87
()()	I star observation bed days (see mistrations						
7.00 3.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 279. 35	88

Health Financial Systems	JOHNSON MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019	Date/Time Pre 8/27/2020 4:0	pared: 1 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	475, 352	7, 907, 659	0. 06011	3 1, 132, 225	68, 061	90.00
91.00 Nursing School cost	0	7, 907, 659	0.00000	0 1, 132, 225	0	91.00
92.00 Allied health cost	0	7,907,659	0.00000	0 1, 132, 225	0	92.00
93.00 All other Medical Education	0	7, 907, 659	0.00000	0 1, 132, 225	0	93.00

Health Financial Systems JOHNSON MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0001	Period:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019		narod
			10 12/31/2019	8/27/2020 4:0	
	Title	e XVIII	Hospi tal	PPS	
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	
INPATIENT ROUTINE SERVICE COST CENTERS		-			
30.00 03000 ADULTS & PEDIATRICS			3, 491, 819		30.00
31.00 O3100 I NTENSI VE CARE UNI T			564, 165		31.00
41.00 04100 SUBPROVI DER - I RF			0		41.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS		0. 2027	70 1, 855, 260	376, 228	50.00
53. 00 05300 ANESTHESI OLOGY		0. 2027			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0418			
60. 00 06000 LABORATORY		0. 1230			
65. 00 06500 RESPIRATORY THERAPY		0. 1902			
66. 00 06600 PHYSICAL THERAPY		0. 3108			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3732			
68.00 06800 SPEECH PATHOLOGY		0. 5927			1
69. 00 06900 ELECTROCARDI OLOGY		0. 2174			1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2848			•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3271			1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 3957			•
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3701			
76. 00 03020 ONCOLOGY		1.0137			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 6238			76.97
OUTPATIENT SERVICE COST CENTERS			·	. · · ·	
90. 00 09000 CLI NI C		0. 2345	55 5, 606	1, 315	90.00
91. 00 09100 EMERGENCY		0. 1735	74 1, 701, 666	295, 399	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6020	240,009	144, 508	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			17, 296, 443	4, 251, 903	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			17, 296, 443		202.00
-					

Health Financial Systems JO	HNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 15-0001	Peri od:	Worksheet D-3	
				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 8/27/2020 4:0	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				433, 804		30.00
31. 00 03100 I NTENSI VE CARE UNI T				8, 286		31.00
41.00 04100 SUBPROVI DER – I RF				0		41.00
43. 00 04300 NURSERY				0		43.00
ANCILLARY SERVICE COST CENTERS			-	-		
50.00 05000 OPERATING ROOM			0. 2027			1
53. 00 05300 ANESTHESI OLOGY			0. 0418			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 1230			54.00
60. 00 06000 LABORATORY			0. 1902			60.00
65. 00 06500 RESPI RATORY THERAPY			0. 3108			65.00
66. 00 06600 PHYSI CAL THERAPY			0. 3371			66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 3732			67.00
68.00 06800 SPEECH PATHOLOGY			0. 5927		230	
69. 00 06900 ELECTROCARDI OLOGY			0. 2105		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY			0. 2848			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 3271		8, 990	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0. 3957		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 3701		28, 221	73.00
76. 00 03020 ONCOLOGY			0. 8959		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 6238	31 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC			0. 2345		-	90.00
91.00 09100 EMERGENCY			0. 1735		8, 588	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 6020		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 t				593, 970	127, 881	
201.00 Less PBP Clinic Laboratory Services-Progra	m only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)				593, 970		202.00

	Financial Systems JOHNSON MEMORIA ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Peri od: From 01/01/2019 To 12/31/2019	u of Form CMS-: Worksheet E Part A Date/Time Pre 8/27/2020 4:0	pared
		Title XVIII	Hospi tal	8/2//2020 4:0 PPS	
			-	1.00	
1	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occur	ring prior to October 1	(500	0	
01	instructions)	This piror to betaber i	(366	0	1.0
02	DRG amounts other than outlier payments for discharges occur	ring on or after October	1 (see	5, 496, 573	1.C
03	instructions) DRG for federal specific operating payment for Model 4 BPCI	for discharges occurring	prior to October	0	1.0
	1 (see instructions)				
04	DRG for federal specific operating payment for Model 4 BPCI October 1 (see instructions)	for discharges occurring	on or after	0	1.0
00	Outlier payments for discharges. (see instructions)				2.0
01	Outlier reconciliation amount	ti ana)		0	
02 03	Outlier payment for discharges for Model 4 BPCI (see instruc Outlier payments for discharges occurring prior to October 1	-		0	
04	Outlier payments for discharges occurring on or after October			109, 114	
00	Managed Care Simulated Payments			0	
00	Bed days available divided by number of days in the cost rep	orting period (see instr	ructions)	46.44	4.0
00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mo	st recent cost reporting	period ending on	0.00	5.0
	or before 12/31/1996. (see instructions)		por ou onaring on	0100	
00	FTE count for allopathic and osteopathic programs that meet new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-	on to the cap for	0.00	6.0
00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f	⁻ ) (1) (i v) (B) (1)	0.00	7.
01	ACA § 5503 reduction amount to the IME cap as specified under			0.00	
~~	cost report straddles July 1, 2011 then see instructions.		C.	0.00	
00	Adjustment (increase or decrease) to the FTE count for allop affiliated programs in accordance with 42 CFR 413.75(b), 413			0.00	8.
	1998), and 67 FR 50069 (August 1, 2002).		140 (May 12,		
01	The amount of increase if the hospital was awarded FTE cap s	lots under § 5503 of the	ACA. If the cost	0.00	8.
02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap s	lots from a closed teach	ing hospital	0.00	8.
02	under § 5506 of ACA. (see instructions)		ing nospi tai	0.00	0.
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus li	nes (8, 8,01 and 8,02)	(see	0.00	9.
. 00	instructions) FTE count for allopathic and osteopathic programs in the cur	rent vear from vour reco	ords	0.00	10.
	FTE count for residents in dental and podiatric programs.			0.00	
-	Current year allowable FTE (see instructions)			0.00	
. 00	Total allowable FTE count for the prior year.		-t	0.00	
. 00	Total allowable FTE count for the penultimate year if that y otherwise enter zero.	ear ended on or arter se	ptemper 30, 1997,	0.00	14.
. 00	Sum of lines 12 through 14 divided by 3.			0.00	15.
	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital cl	osure		0.00	
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line	4)		0.00 0.000000	
	Prior year resident to bed ratio (see instructions)	-).		0.000000	
. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.
	IME payment adjustment (see instructions)			0	
. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 4	22 of the MMA		0	22.
. 00	Number of additional allopathic and osteopathic IME FTE resi		CFR 412.105	0.00	23.
	(f)(1)(iv)(C)				
. 00	IME FTE Resident Count Over Cap (see instructions)	lower of line 22 or lin	0.24 (500	0.00	
. 00	If the amount on line 24 is greater than -0-, then enter the instructions)	Tower of time 23 of the	le 24 (See	0.00	25.
. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.
1	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	
. 01 . 00	IME add-on adjustment amount - Managed Care (see instruction Total IME payment ( sum of lines 22 and 28)	15)		0	
. 00	Total IME payment - Managed Care (sum of lines 22.01 and 28.	01)		0	
	Disproportionate Share Adjustment	·			1
	Percentage of SSI recipient patient days to Medicare Part A	patient days (see instru	icti ons)	1.71	
	Percentage of Medicaid patient days (see instructions)			23.07 24.78	
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instruction	s)		24.78 9.66	
	Disproportionate share adjustment (see instructions)	- /		132, 742	

	Financial Systems JOHNSON MEMORIAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0001	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2019 To 12/31/2019	Part A Date/Time Prep 8/27/2020 4:0	
		Title XVIII	Hospi tal	PPS	i piii
			Prior to 10/1		
	Uncompensated Care Adjustment		1.00	2.00	
35.00			0	0	35.00
35.01	Factor 3 (see instructions)		0. 00000000	0. 00000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se	e 815, 209	731, 656	35.02
25 02	instructions)		(00.701	102 012	25 01
35.03 36.00	Pro rata share of the hospital uncompensated care payment amo Total uncompensated care (sum of columns 1 and 2 on line 35.0		609, 731 793, 644	183, 913	35.03 36.00
00.00	Additional payment for high percentage of ESRD beneficiary di				00.00
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding		0		40.00
	652, 682, 683, 684 and 685 (see instructions)	oo (of (of (			
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	983, 684 an 685. (see	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41.01
	an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	J J ,	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	32, 683, 684 an 685. (see	0		43.00
44.00	instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
	days)	<i>by</i> 1110 11 at 11 aca <i>by</i> 7	01000000		
45.00	Average weekly cost for dialysis treatments (see instructions		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46.00
47.00 48.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	mall rural bosnitals	6, 532, 073		47.00 48.00
40.00	only. (see instructions)		0		40.00
				Amount	
10.00		<u></u>		1.00	10.00
49.00 50.00	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I an			6, 532, 073 445, 200	49.00 50.00
51.00	Exception payment for inpatient program capital (West. L, Pt.			443, 200	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment	0)		0	54.0 [°]
55.00 56.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr			0	55.00 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35)	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.		in ough oo).	Ő	58.00
59.00	Total (sum of amounts on lines 49 through 58)			6, 977, 273	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	sline 60)		6, 977, 273	61.00
	Deductibles billed to program beneficiaries			726, 724	62.00
62.00	Coinsurance billed to program beneficiaries			682	
63.00					
63.00 64.00	Allowable bad debts (see instructions)			26, 858	
63.00 64.00 65.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	ruoti ono)		17, 458	65.00
63.00 64.00 65.00 66.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		17, 458 26, 858	65.00 66.00
63.00 64.00 65.00 66.00 67.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63)		ee instructions)	17, 458 26, 858 6, 267, 325	65.00 66.00 67.00
63.00 64.00 65.00 66.00 67.00 68.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s		17, 458 26, 858 6, 267, 325 0	65.00 66.00 67.00 68.00
63.00 64.00 65.00 66.00 67.00 68.00 69.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	applicable to MS-DRGs (s		17, 458 26, 858 6, 267, 325 0 0	65.00 66.00 67.00 68.00 69.00
63.00 64.00 65.00 66.00 67.00 68.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s (For SCH see instruction	s)	17, 458 26, 858 6, 267, 325 0	65.00 66.00 67.00 68.00 69.00 70.00
63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	applicable to MS-DRGs (s (For SCH see instruction	s)	17, 458 26, 858 6, 267, 325 0 0 0	65.00 66.00 67.00 68.00 69.00 70.00 70.50
63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.50	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	applicable to MS-DRGs (s (For SCH see instruction	s)	17, 458 26, 858 6, 267, 325 0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 70.00 70.50 70.50
63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	applicable to MS-DRGs (s (For SCH see instruction ration) adjustment (see	s)	17, 458 26, 858 6, 267, 325 0 0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 70.00 70.50 70.8° 70.8° 70.8°
63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	applicable to MS-DRGs (s (For SCH see instruction ration) adjustment (see	s)	17, 458 26, 858 6, 267, 325 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 70.00 70.50 70.83 70.88 70.88 70.90
63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.50 70.87 70.88 70.89 70.90 70.91	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	applicable to MS-DRGs (s (For SCH see instruction ration) adjustment (see	s)	17, 458 26, 858 6, 267, 325 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 70.50 70.8 70.8 70.8 70.8 70.90 70.9
63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.50 70.50 70.87 70.88 70.89 70.90 70.91 70.92	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	applicable to MS-DRGs (s (For SCH see instruction ration) adjustment (see	s)	17, 458 26, 858 6, 267, 325 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 70.50 70.8 70.8 70.8 70.8 70.8 70.90 70.90 70.9
63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.50 70.87 70.88 70.89 70.90 70.91	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	applicable to MS-DRGs (s (For SCH see instruction ration) adjustment (see	s)	17, 458 26, 858 6, 267, 325 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65.00 66.00 67.00 68.00 69.00 70.50 70.87 70.88 70.88 70.90 70.90 70.92

	Financial Systems JOHNSON MEMORIAL ATLON OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider C	CN: 15-0001	Peri od:	u of Form CMS-2 Worksheet E	
			UN. 15 0001	From 01/01/2019 To 12/31/2019	Part A Date/Time Pre	
		Ti the	XVIII	Hocni tal	8/27/2020 4:0 PPS	1 pm
		i		Hospi tal (yyyy)	Amount	
				0	1.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)	n column O		0		70.96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70.97
70. 98	Low Volume Payment-3				0	70.98
	HAC adjustment amount (see instructions)				0	70.99
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			6, 309, 490	
71.01	Sequestration adjustment (see instructions)				126, 190	
1.02 1.03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs				0	71.02 71.03
	Interim payments				6, 130, 668	
	Interim payments				0, 130, 000	72.00
	Tentative settlement (for contractor use only)				0	73.00
	Tentative settlement-PARHM (for contractor use only)				0	73.00
	Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	2, 72, and			52, 632	74.00
74.01	Balance due provider/program-PARHM (see instructions)					74.01
	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	nce with			84, 437	75.OC
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1		00.00
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	90.00
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instr				0	92.00
	Capital outlier reconciliation adjustment amount (see instruc				0	93.00
	The rate used to calculate the time value of money (see instr Time value of money for operating expenses (see instructions)				0.00	94.00 95.00
	Time value of money for capital related expenses (see instructions)				0	96.00
/0.00	The value of money for capital related expenses (see thist de	(1013)	1	Prior to 10/1	÷	70.00
				1.00	2.00	
	HSP Bonus Payment Amount					
00.00	HSP bonus amount (see instructions)				2.00	100.00
00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
00. 00 01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0.0000000000	2.00 0 0.000000000	101. 00
00. 00 01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	s)		1.00	2.00 0 0.000000000	101. 00
00. 00 01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	s)		1.00 0 0.0000000000 0	2.00 0 0.000000000 0	101. 00 102. 00
00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			1.00 0.000000000 0 0.000000000000000000	2.00 0 0.000000000 0 0.0000	101.00 102.00 103.00
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions	)		1.00 0 0.0000000000 0	2.00 0 0.000000000 0 0.0000	101.00 102.00 103.00
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst	) ration) Adju		1.00 0.000000000 0 0.000000000000000000	2.00 0 0.000000000 0 0.0000 0	101.00 102.00 103.00 104.00
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	) ration) Adju		1.00 0.000000000 0 0.000000000000000000	2.00 0 0.000000000 0 0.0000 0	101.00 102.00 103.00
00. 00 01. 00 02. 00 03. 00 04. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	) ration) Adju riod under		1.00 0.000000000 0 0.000000000000000000	2.00 0 0.000000000 0 0.0000 0	101.00 102.00 103.00 104.00 200.00
00. 00 01. 00 02. 00 03. 00 04. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin	) ration) Adju riod under		1.00 0.000000000 0 0.000000000000000000	2.00 0.000000000 0 0.0000 0	101.00 102.00 103.00 104.00 200.00
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	) ration) Adju riod under		1.00 0.000000000 0 0.000000000000000000	2.00 0.000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
00.00 01.00 02.00 03.00 04.00 00.00 00.00 00.00 00.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin	) ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0	101.00 102.00 103.00 104.00
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 00. 00 00. 00 00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	) ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	) ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	) ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	) ration) Adju riod under e 49) first year	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0 0	101.00 102.00 103.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 05.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0 0	101.00 102.00 103.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 05.00 06.00 07.00 08.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101.00 102.00 103.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00
00.00 01.00 02.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0 0.000000000 0 0.0000 0 trati on	101.00 102.00 103.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare IPPS payments (see instructions) Redicare Part A Inpatient Reimbursement Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101.00 102.00 103.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 05.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101.00 102.00 103.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00
00.00 01.00 02.00 03.00 04.00 00.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	) ration) Adju riod under e 49) first year first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 tration	101.00 102.00 103.00 200.00 201.00 202.00 203.00 204.00 206.00 206.00 207.00 208.00 209.00 210.00 211.00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	) ration) Adju riod under e 49) first year first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0 0.0000 0	101.00 102.00 103.00 200.00 201.00 202.00 203.00 203.00 204.00 205.00 206.00 207.00 208.00 209.00 210.00 211.00 211.00
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 1.	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	) ration) Adju riod under e 49) first year ructions) line 59) 211)	of the curre	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0 0.0000 0	101.00 102.00 103.00 200.00 201.00 202.00 203.00 204.00 205.00

	Financial Systems LUME CALCULATION EXHIBIT 4		JOHNSON MEMORI	Provider C	F	Period: From 01/01/2019 To 12/31/2019	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Pre 8/27/2020 4:0	t 4 pared
		l i ne	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Hospital Period On/After 10/01	PPS Total (Col 2 through 4)	
0	DDC empurity other than outling	0	1.00	2.00	3.00	4.00	5.00	1
00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.
)1	DRG amounts other than outlier payments for discharges	1.01	0	0	(		0	1.
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	5, 496, 573	0		5, 496, 573	5, 496, 573	1.
)3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	Ο	0	(		Ο	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.
00	Outlier payments for	2.00						2.
)1	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2.02	0	0	(	0 0	0	2.
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	(		0	2.
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	109, 114	0		109, 114	109, 114	2.
00	Operating outlier reconciliation	2.01	0	0			0	
00	Managed care simulated payments	3.00	0	0	(	0 0	0	4.
	Indirect Medical Education Adju	ustment			1	1		1
00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.
0	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6
)1	IME payment adjustment for managed care (see instructions)	22.01	0	0	(	0 0	0	6
	Indirect Medical Education Adju	stment for th	e Add-on for Se	ection 422 of t	the MMA			
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0. 000000			7
0	IME adjustment (see instructions)	28.00	0	0	(	0 0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	(	0 0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	_	
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9
	Disproportionate Share Adjustme							
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0966	0. 0966	0. 0966	o 0. 0966		10
	Disproportionate share adjustment (see instructions)	34.00	132, 742	0				
	Uncompensated care payments Additional payment for high per	36.00	793,644 RD beneficiary	0 discharges	609, 73	183, 913	793, 644	1
00	Total ESRD additional payment (see instructions)	46. 00	0	0 O	(	0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47.00 48.00	6, 532, 073 0	0 0		5, 922, 342 0 0		13 14
00	<pre>small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)</pre>	49.00	6, 532, 073	0	609, 731	5, 922, 342	6, 532, 073	15

	Financial Systems		JOHNSON MEMORI		CN 15 0001		u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/27/2020 4:0	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	445, 200	0	-114, 79	94 559, 994	445, 200	16.0
17.00	Special add-on payments for new technologies	54.00	0	0		0 0	0	17.0
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.0 17.0
18.00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.0
19 00	SUBTOTAL			0	494, 93	6, 482, 336	6, 977, 273	19 0
		W/S L, line	(Amounts from L)				6,777,276	1710
	T	0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1.00 1.01	445, 200 0	0 0		15 557, 415 0 0	445, 200 0	
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2.00 2.01	0 0	0 0		79 2, 579 0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0. 0000		22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.000	0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25. C
26.00	Total prospective capital payments (see instructions)	12.00	445, 200	0	-114, 79	94 559, 994	445, 200	26. C
		W/S E, Part A						
		line	E, Part A)	0.00	0.00	4.00	F 00	
07.00	Law all and a distant	0	1.00	2.00	3.00	4.00	5.00	07.0
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 00000	0 0. 000000 0	0	27.0 28.0
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100. 0

	Financial Systems	JOHNSON MEMOR				u of Form CMS-2	2552-10
IOSPI I	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provider C		Period: From 01/01/2019	Worksheet E Part A Exhibi	t 5
					To 12/31/2019	Date/Time Pre	pared:
				XVIII	lloonitol	8/27/2020 4:0	1 pm
		Wkst. E, Pt.	Amt. from	Period to	Hospital Period on	PPS Total (col s.	
		A, line	Wkst. E, Pt.	10/01	after 10/01	2 and 3)	
			A)				
		0	1.00	2.00	3.00	4.00	
. 00	DRG amounts other than outlier payments	1.00					1.00
. 01	DRG amounts other than outlier payments for	1.01	0		0	0	1.01
~~	discharges occurring prior to October 1	1.00	F 404 F70		5 404 570	F 404 F70	1 00
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	5, 496, 573		5, 496, 573	5, 496, 573	1.02
03	DRG for Federal specific operating payment	1.03	0		0	0	1.03
00	for Model 4 BPCI occurring prior to October	1.00	0		0	Ŭ	1.00
	1						
04	DRG for Federal specific operating payment	1.04	0		0	0	1.04
	for Model 4 BPCI occurring on or after						
	October 1						
00	Outlier payments for discharges (see	2.00					2.00
	instructions)						
01	Outlier payments for discharges for Model 4	2.02	0		0 0	0	2.01
00	BPCI	2.02					2.02
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0		0	0	2.02
03	Outlier payments for discharges occurring on	2.04	109, 114		109, 114	109, 114	2.03
05	or after October 1 (see instructions)	2.04	107, 114		107, 114	107, 114	2.00
.00	Operating outlier reconciliation	2.01	0		o o	0	3.00
.00	Managed care simulated payments	3.00	0		0 0	0	4.00
	Indirect Medical Education Adjustment						
. 00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0.00000		5.00
	(see instructions)						
. 00	IME payment adjustment (see instructions)	22.00	0		0 0	-	6.00
. 01	IME payment adjustment for managed care (see	22. 01	0		0 0	0	6. 01
	instructions)						
00	Indirect Medical Education Adjustment for the		0. 000000	0. 00000	0.00000		7 00
00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.00000	0.00000		7.00
. 00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
. 01	IME payment adjustment add on for managed	28.00	0				8.0
	care (see instructions)	20101	Ū			, i i i i i i i i i i i i i i i i i i i	0.0.
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
. 01	Total IME payment for managed care (sum of	29. 01	0		0 0	0	9.01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment	[			-		
0.00	Allowable disproportionate share percentage	33.00	0. 0966	0. 096	6 0. 0966		10.00
4 00	(see instructions)	04.00	100 740		100 740	100 740	11 00
1.00	Disproportionate share adjustment (see	34.00	132, 742		0 132, 742	132, 742	11.00
1. 01	instructions) Uncompensated care payments	36.00	793, 644	609, 73	1 183, 913	793, 644	11 01
1.01	Additional payment for high percentage of ESI			007,73	1 105, 715	//3,044	11.0
2.00	Total ESRD additional payment (see	46. 00	0		0 0	0	12.00
2.00	instructions)	10.00	0		0	, o	12.00
3.00	Subtotal (see instructions)	47.00	6, 532, 073	609, 73	1 5, 922, 342	6, 532, 073	13.00
4.00	Hospital specific payments (completed by SCH		0		0 0	0	
	and MDH, small rural hospitals only.) (see						
	instructions)						
5.00	Total payment for inpatient operating costs	49.00	6, 532, 073	609, 73	1 5, 922, 342	6, 532, 073	15.00
	(see instructions)						
5.00	Payment for inpatient program capital (from	50.00	445, 200	-114, 79	4 559, 994	445, 200	16.00
	Wkst. L, Pt. I, if applicable)	54.00					47.00
7.00	Special add-on payments for new technologies	54.00	0		0 0	0	17.00
7.01	Net organ acquisition cost	40.00					17.0
7.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0		17.02
8.00	Capital outlier reconciliation adjustment	93.00	0		o o	0	18.00
5.00	amount (see instructions)	75.00			0		
9.00	SUBTOTAL			494, 93	6, 482, 336	6, 977, 273	19. OC
		1	1	, , , , , , , , , , , , , , , , , ,	.,, 500	, , = / 0	

Health Financial Systems	JOHNSON MEMOR				u of Form CMS-:	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CA	LCULATION EXHIBIT 5			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/27/2020 4:0	pared:
			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	445, 200	-112, 21	15 557, 415	445, 200	20.00
20.01 Model 4 BPCI Capital DRG other than out!	ier 1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	0	-2, 57	2, 579	0	21.00
21.01 Model 4 BPCI Capital DRG outlier payment	ts 2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (s instructions)	see 5.00	0. 0000	0.000	0. 0000		22.00
23.00 Indirect medical education adjustment (s instructions)	see 6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percent (see instructions)	tage 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	445, 200	-114, 79	559, 994	445, 200	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	I 70. 96	0		0	0	28.00
29.00 Low volume adjustment on or after Octobe	er 1 70.97	0		0	0	29.00
30.00 HVBP payment adjustment (see instruction	ns) 70. 93	49, 436		0 49, 436	49, 436	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30.01
31.00 HRR adjustment (see instructions)	70. 94	-7, 271		0 -7,271	-7, 271	31.00
31.01 HRR adjustment for HSP bonus payment (se instructions)	e 70. 91	0		0 0	0	31.01
					(Amt. to Wkst. E, Pt.	
	0	1.00	2.00	3.00	A) 4.00	
32.00 HAC Reduction Program adjustment (see	70. 99	1.00	2.00	0 0		32.00
instructions) 100.00 Transfer HAC Reduction Program adjustmer Wkst. E, Pt. A.	nt to	Ν				100.00

2.00       Medical and other services reimbursed under OPPS (see instructions)       8,638,6         3.00       OPPS payments       6,480,0         4.00       Outlier payment (see instructions)       17,6         5.00       Enter the hospital specific payment to cost ratio (see instructions)       0.0         6.00       Line 2 times line 5       0.0         7.00       Sum of lines 3, 4, and 4.01, divided by line 6       0.0         8.00       Transitional corridor payment (see instructions)       0.0         9.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200       0.0         0.00       Organ acquisitions       8         11.00       Total cost (sum of lines 1 and 10) (see instructions)       8         COMPUTATION OF LESSER OF COST OC CHARGES       2,5         Reasonable charges       2,5         12.00       Ancillary service charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2,5         13.00       Organ acquisition charges (sum of lines 12 and 13)       2,5         14.00       Total reasonable charges       2,5         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.00000         17.00       Rati o of line 15 to line	Prepared:           :: 01 pm           33           33           1.00           53           2.00           91           3.00           49           4.00           0           5.00           0           0           5.00           0           0           33           10.00           33           11.00           10           12.00           0           13.00           10           12.00           0           13.00           10           12.00           0           15.00           0           15.00           0           15.00           0           15.00           0           16.00           00           17.00           18.00           77           19.00
PART B - MEDICAL AND OTHER HEALTH SERVICES         1.00           PART B - MEDICAL AND OTHER HEALTH SERVICES         1.00           Medical and other services (see instructions)         8,638,6           3.00         OPPS payments         8,638,6           4.01         Outlier payment (see instructions)         8,638,6           5.00         Enter the hospital specific payment to cost ratio (see instructions)         17,6           6.00         Line 2 times line 5         0.0           7.00         Sum of lines 3, 4, and 4.01, divided by line 6         0.0           8.00         Torasitional corridor payment (see instructions)         0.0           9.00         Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200         0.0           10.00         Total cost (sum of lines 1 and 10) (see instructions)         2.0           10.00         Total cost (sum of lines 1 and 10) (see instructions)         2.3           10.00         Total cost (sum of lines 1 and 10) (see instructions)         2.3           10.01         Total cost (sum of lines 1 and 10)         2.4           11.00         Total cost (sum of lines 12 and 13)         2.3           12.00         Ancillary service charges         2.3           12.00         Ancillary service charges         2.3	33         1.00           53         2.00           91         3.00           49         4.00           0         4.01           00         5.00           0         6.00           0         7.00           0         8.00           0         9.00           0         10.00           33         11.00           10         12.00           0         13.00           10         14.00           0         15.00           0         15.00           0         17.00           10         18.00
PART B - MEDICAL AND OTHER HEALTH SERVICES       1.00         1.00       Medical and other services (see instructions)       8,638,6         2.00       Medical and other services reimbursed under OPPS (see instructions)       8,638,6         3.00       OPPS payments       8,638,6         4.00       Outlier reconciliation amount (see instructions)       17,6         4.01       Outlier reconciliation amount (see instructions)       17,6         5.00       Enter the hospital specific payment to cost ratio (see instructions)       0.0         6.00       Line 2 times line 5       0.0         7.00       Sum of lines 3, 4, and 4.01, divided by line 6       0.0         8.00       Transitional corridor payment (see instructions)       0.0         9.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200       0.0         0.00       Organ acquisitions       2.0         11.00       Total cost (sum of lines 1 and 10) (see instructions)       2.0         0.00       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2.0         11.00       Total reasonable charges       2.0         12.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	33         1.00           53         2.00           91         3.00           49         4.00           0         4.01           00         5.00           0         4.01           00         5.00           0         8.00           0         9.00           0         10.00           33         11.00           10         12.00           0         13.00           10         14.00           0         15.00           0         16.00           00         17.00           10         18.00
PART B - MEDICAL AND OTHER HEALTH SERVICES         1.00       Medical and other services (see instructions)       68         2.00       Medical and other services (see instructions)       8, 638, 638, 638, 640, 640, 640, 640, 640, 640, 640, 640	$\begin{array}{cccccccccccccccccccccccccccccccccccc$
1.00       Medical and other services (see instructions)       8       68         2.00       Medical and other services reimbursed under OPPS (see instructions)       8       6.480         3.00       OPPS payments       6       480         4.01       Outlier payment (see instructions)       17.6         5.00       Enter the hospital specific payment to cost ratio (see instructions)       0.1         6.00       Line 2 times line 5       0.1         7.00       Sum of lines 3, 4, and 4.01, divided by line 6       0.1         8.00       Transitional corridor payment (see instructions)       0.1         9.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200       0.1         10.00       Organ acquisitions       8         11.00       Total cost (sum of lines 1 and 10) (see instructions)       8         22.00       Ancillary service charges       2.1         22.00       Ancillary service charges       2.1         13.00       Organ acquisition charges (sum of lines 12 and 13)       2.1         Customary charges       2.1         14.00       Total cost (sum of lines 12 and 13)       2.1         Customary charges       0       0         15.00       Aggregate amount actually collected from pat	$\begin{array}{cccccccccccccccccccccccccccccccccccc$
3.00       OPPS payments       6,480,0         4.00       Outlier payment (see instructions)       17,4         0.01       Outlier conciliation amount (see instructions)       17,4         5.00       Enter the hospital specific payment to cost ratio (see instructions)       0.0         6.00       Line 2 times line 5       0.10         7.00       Sum of lines 3, 4, and 4.01, divided by line 6       0.0         8.00       Transitional corridor payment (see instructions)       0.10         0.0100       Organ acquisitions       0.11         11.00       Total cost (sum of lines 1 and 10) (see instructions)       20         COMPUTATION OF LESSER OF COST OR CHARGES       Reasonable charges       2.10         Reasonable charges       2.10       2.10       2.10         13.00       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2.10       2.10         14.00       Total reasonable charges       2.10       2.10       2.10         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       2.10         16.00       Ancurs that would have been realized from patients liable for payment for services on a charge basis       2.20         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.00000	91       3.00         49       4.00         0       4.01         00       5.00         0       6.00         0       7.00         0       8.00         0       9.00         0       10.00         33       11.00         10       12.00         0       13.00         10       14.00         0       15.00         0       17.00         10       18.00
4.00       Outlier payment (see instructions)       17, 6         4.01       Outlier reconciliation amount (see instructions)       0.0         5.00       Enter the hospital specific payment to cost ratio (see instructions)       0.0         6.00       Line 2 times line 5       0.0         7.00       Sum of lines 3, 4, and 4.01, divided by line 6       0.0         8.00       Transitional corridor payment (see instructions)       0.1         9.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200       0.0         10.00       Organ acquisitions       2         11.00       Total cost (sum of lines 1 and 10) (see instructions)       2         COMPUTATION OF LESER OF COST OR CHARGES       2.1         Reasonable charges       2.1         12.00       Ancillary service charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2.1         14.00       Total reasonable charges (sum of lines 12 and 13)       2.1         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.0000         17.00       Ratio of line 15 to line 16 (not to exceed 1.00000)       0.0000       2.1         18.00       Data customary charges (see instructions)       2.1       2.1 </td <td>49         4.00           0         4.01           00         5.00           0         6.00           0         8.00           0         9.00           0         10.00           33         11.00           10         12.00           0         13.00           10         14.00           0         15.00           0         17.00           10         18.00</td>	49         4.00           0         4.01           00         5.00           0         6.00           0         8.00           0         9.00           0         10.00           33         11.00           10         12.00           0         13.00           10         14.00           0         15.00           0         17.00           10         18.00
4.01       Outlier reconciliation amount (see instructions)       0.1         5.00       Enter the hospital specific payment to cost ratio (see instructions)       0.0         6.00       Line 2 times line 5       0.0         7.00       Sum of lines 3, 4, and 4.01, divided by line 6       0.0         8.00       Transitional corridor payment (see instructions)       0.1         9.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200       0.1         10.00       Organ acquisitions       0         11.00       Total cost (sum of lines 1 and 10) (see instructions)       0         12.00       Ancillary service charges       2.0         12.00       Ancillary service charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2.3         14.00       Total reasonable charges (sum of lines 12 and 13)       2.3         Customary charges       2.3         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.00000         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.00000         18.00       Total customary charges (see instructions)       2.3         19.00 <td< td=""><td>0         4.01           00         5.00           0         6.00           0         8.00           0         9.00           0         10.00           33         11.00           10         12.00           0         13.00           10         14.00           0         15.00           0         16.00           00         17.00           10         18.00           77         19.00</td></td<>	0         4.01           00         5.00           0         6.00           0         8.00           0         9.00           0         10.00           33         11.00           10         12.00           0         13.00           10         14.00           0         15.00           0         16.00           00         17.00           10         18.00           77         19.00
6.00       Line 2 times line 5       0.1         7.00       Sum of lines 3, 4, and 4.01, divided by line 6       0.1         8.00       Transitional corridor payment (see instructions)       0.1         9.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200       0.1         10.00       Organ acquisitions       1.1         11.00       Total cost (sum of lines 1 and 10) (see instructions)       8         COMPUTATION OF LESSER OF COST OR CHARGES       2.3         Reasonable charges       2.3         12.00       Ancillary service charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2.3         13.00       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2.3         14.00       Total reasonable charges       2.3         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.0000         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.00000         18.00       Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       2.3         19.00       Excess of customary charges over customary charges (complete only if line 11 exceeds line 18) (see instructions)       1.4         20.00	$\begin{array}{cccccc} 0 & 6 & 00 \\ 00 & 7 & 00 \\ 0 & 8 & 00 \\ 0 & 9 & 00 \\ 0 & 10 & 00 \\ 33 & 11 & 00 \\ \hline 10 & 12 & 00 \\ 0 & 13 & 00 \\ 10 & 14 & 00 \\ \hline 0 & 15 & 00 \\ 0 & 16 & 00 \\ 00 & 17 & 00 \\ 10 & 18 & 00 \\ 77 & 19 & 00 \\ \end{array}$
7.00       Sum of lines 3, 4, and 4.01, divided by line 6       0.         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.         10.00       Organ acquisitions       2         11.00       Total cost (sum of lines 1 and 10) (see instructions)       2         COMPUTATION OF LESSER OF COST OR CHARGES       2.0         Reasonable charges       2.0         12.00       Ancillary service charges (sum of lines 12 and 13)         Customary charges       2.0         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis         16.00       Amounts that would have been realized from patients liable for payment for services on a charge basis         16.00       Ratio of line 15 to line 16 (not to exceed 1.00000)       0.0000         17.00       Ratio of line 15 to line 16 (not to exceed 1.00000)       0.0000         18.00       Total customary charges (see instructions)       2.5         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       1.4         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       1.4 <td>$\begin{array}{ccccccc} 00 &amp; 7 &amp; 00 \\ 0 &amp; 8 &amp; 00 \\ 0 &amp; 9 &amp; 00 \\ 0 &amp; 10 &amp; 00 \\ 33 &amp; 11 &amp; 00 \\ \hline \\ 10 &amp; 12 &amp; 00 \\ 0 &amp; 13 &amp; 00 \\ 10 &amp; 14 &amp; 00 \\ \hline \\ 0 &amp; 15 &amp; 00 \\ 0 &amp; 16 &amp; 00 \\ 0 &amp; 17 &amp; 00 \\ 10 &amp; 18 &amp; 00 \\ 77 &amp; 19 &amp; 00 \\ \end{array}$</td>	$\begin{array}{ccccccc} 00 & 7 & 00 \\ 0 & 8 & 00 \\ 0 & 9 & 00 \\ 0 & 10 & 00 \\ 33 & 11 & 00 \\ \hline \\ 10 & 12 & 00 \\ 0 & 13 & 00 \\ 10 & 14 & 00 \\ \hline \\ 0 & 15 & 00 \\ 0 & 16 & 00 \\ 0 & 17 & 00 \\ 10 & 18 & 00 \\ 77 & 19 & 00 \\ \end{array}$
8.00       Transitional corridor payment (see instructions)         9.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200         10.00       Organ acquisitions         11.00       Total cost (sum of lines 1 and 10) (see instructions)         COMPUTATION OF LESSER OF COST OR CHARGES         Reasonable charges         12.00       Ancillary service charges         12.00       Ancillary service charges (sum of lines 12 and 13)         Customary charges       2,3         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis         16.00       Amounts that would have been realized from patients liable for payment for services on a charge basis         16.00       Ratio of line 15 to line 16 (not to exceed 1.000000)         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)         18.00       Total customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)         19.00       Excess of customary charges over customary charges (complete only if line 11 exceeds line 18) (see instructions)         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0         8.00           0         9.00           0         10.00           33         11.00           10         12.00           0         13.00           10         14.00           0         15.00           0         16.00           00         17.00           10         18.00           77         19.00
10.00       Organ acquisitions       8         11.00       Total cost (sum of lines 1 and 10) (see instructions)       8         COMPUTATION OF LESSER OF COST OR CHARGES       8         Reasonable charges       2, 3         12.00       Ancillary service charges       2, 3         13.00       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2, 3         14.00       Total reasonable charges (sum of lines 12 and 13)       2, 3         Customary charges       2       3         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.0000         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.0000         18.00       Total customary charges (see instructions)       2, 3         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       1, 4         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       1, 4	0 10.00 33 11.00 10 12.00 0 13.00 10 14.00 0 15.00 0 16.00 00 17.00 10 18.00 77 19.00
11.00       Total cost (sum of lines 1 and 10) (see instructions)       8         COMPUTATION OF LESSER OF COST OR CHARGES       Reasonable charges         12.00       Ancillary service charges       2,3         13.00       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2,3         14.00       Total reasonable charges (sum of lines 12 and 13)       2,3         Customary charges       2,3         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.0000         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.0000         18.00       Total customary charges (see instructions)       2,3         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       1,4         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       1,4	33         11.00           10         12.00           0         13.00           10         14.00           0         15.00           0         16.00           00         17.00           10         19.00
COMPUTATION OF LESSER OF COST OR CHARGES         Reasonable charges         12.00       Ancillary service charges         13.00       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)         14.00       Total reasonable charges         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis         16.00       Amounts that would have been realized from patients liable for payment for services on a charge basis         16.00       Ratio of line 15 to line 16 (not to exceed 1.000000)         18.00       Total customary charges (see instructions)         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	10         12.00           0         13.00           10         14.00           0         15.00           0         16.00           00         17.00           10         19.00
12.00       Ancillary service charges       2.3         13.00       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)       2.3         14.00       Total reasonable charges (sum of lines 12 and 13)       2.3         Customary charges       2.3         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       2.3         16.00       Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.0000         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.0000         18.00       Total customary charges (see instructions)       2.3         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       1.4         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       1.4	0 13.00 10 14.00 0 15.00 0 16.00 00 17.00 10 18.00 77 19.00
13.00       Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)         14.00       Total reasonable charges (sum of lines 12 and 13)       2,3         Customary charges       2,3         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.0000         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.0000         18.00       Total customary charges (see instructions)       2,3         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       1,4         20.00       Excess of custower customary charges (complete only if line 11 exceeds line 18) (see instructions)       1,4	0 13.00 10 14.00 0 15.00 0 16.00 00 17.00 10 18.00 77 19.00
14.00       Total reasonable charges (sum of lines 12 and 13)       2,3         Customary charges       Customary charges         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)       0.0000         17.00       Ratio of line 15 to line 16 (not to exceed 1.00000)       0.0000         18.00       Total customary charges (see instructions)       2,3         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       1,4         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       1,4	10         14.00           0         15.00           0         16.00           00         17.00           10         18.00           77         19.00
15.00Aggregate amount actually collected from patients liable for payment for services on a charge basis16.00Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)17.00Ratio of line 15 to line 16 (not to exceed 1.000000)18.00Total customary charges (see instructions)19.00Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)20.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0 16.00 00 17.00 10 18.00 77 19.00
<ul> <li>16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)</li> <li>18.00 Total customary charges (see instructions)</li> <li>19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> </ul>	0 16.00 00 17.00 10 18.00 77 19.00
<ul> <li>had such payment been made in accordance with 42 CFR §413.13(e)</li> <li>17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)</li> <li>18.00 Total customary charges (see instructions)</li> <li>19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</li> <li>20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</li> </ul>	00 17.00 10 18.00 77 19.00
18.00Total customary charges (see instructions)2,319.00Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)1,420.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)1,4	10 18.00 77 19.00
19.00Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)1,420.00Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)1,4	77 19.00
instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	
instructions)	0 20 00
	0 20.00
	33 21.00
22.00 Interns and residents (see instructions)	0 22.00
23.00 Cost of physicians' services in a teaching hospital (see instructions)	0 23.00
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 6,497,7 COMPUTATION OF REIMBURSEMENT SETTLEMENT	40 24.00
25.00 Deductibles and coinsurance amounts (for CAH, see instructions)	0 25.00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 1,277,0	
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 5,221,5) instructions)	56 27.00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50)	0 28.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)	0 29.00
30.00Subtotal (sum of lines 27 through 29)5,221,531.00Primary payer payments6	56 30.00 31 31.00
32.00 Subtotal (line 30 minus line 31) 5,220,9	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	0 22 00
33.00Composite rate ESRD (from Wkst. I-5, line 11)34.00Allowable bad debts (see instructions)94,2	0 33.00 56 34.00
35.00 Adjusted reimbursable bad debts (see instructions) 61,5	
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 94,7	
37.00Subtotal (see instructions)5,282,538.00MSP-LCC reconciliation amount from PS&R-	16 37.00 17 38.00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0 39.00
39.50 Pioneer ACO demonstration payment adjustment (see instructions)	39.50
<ul> <li>39. 97 Demonstration payment adjustment amount before sequestration</li> <li>39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)</li> </ul>	0 39.97 0 39.98
39. 99 RECOVERY OF ACCELERATED DEPRECIATION	0 39.99
40.00 Subtotal (see instructions) 5,282,5	
40.01Sequestration adjustment (see instructions)105, 640.02Demonstration payment adjustment amount after sequestration105, 6	51 40.01 0 40.02
40. 03 Sequestration adjustment-PARHM pass-throughs	40.03
41.00 Interim payments 5,188,5	
41.01  Interim payments-PARHM 42.00  Tentative settlement (for contractors use only)	41.01
42.01 Tentative settlement-PARHM (for contractor use only)	42.01
43.00 Balance due provider/program (see instructions) -11,6	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	43.01 0 44.00
<u>§115. 2</u>	
TO BE COMPLETED BY CONTRACTOR	0 00 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions)	0 90.00 0 91.00
92.00 The rate used to calculate the Time Value of Money 0.	00 92.00
93.00 Time Value of Money (see instructions)	0 93.00
94.00  Total (sum of lines 91 and 93)	0 94.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Pre 8/27/2020 4:0	pared
		Title	XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 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 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)		6, 070, 36	58 0	5, 115, 710 0	1.0 2.0 3.0
	Program to Provider					
. 01 . 02 . 03 . 04 . 05	ADJUSTMENTS TO PROVIDER	12/31/2019 08/13/2019	23, 50 36, 80		72, 842 0 0 0 0	3. ( 3. ( 3. ( 3. ( 3. (
	Provider to Program					
. 50 . 51 . 52 . 53 . 54 . 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		60, 30	0 0 0 0 0 0	0 0 0 0 72, 842	3. 5 3. 5 3. 5 3. 5 3. 5
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)		6, 130, 60	58	5, 188, 552	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) Program to Provider					5.
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
-	Provider to Program					_
50 51 52 99	TENTATIVE TO PROGRAM Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0 0 0 0	0 0 0 0	5. 5. 5. 5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
D1	SETTLEMENT TO PROVIDER		52, 63	32	0	6.
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		6, 183, 30	0 00 Contractor	11,670 5,176,882 NPR Date	6. 7.
				Number	(Mo/Day/Yr)	
					(	

Heal th	Financial Systems JOHNSON MEMORIA	AL HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet E- Part II Date/Time Pre	
				8/27/2020 4:0	
		Title XVIII	Hospi tal	PPS	
				1 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND COST REPORTS	ON			-
1.00	Total hospital discharges as defined in AARA §4102 from Wks		ne 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	/Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestratio	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				-
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ons)		32.00

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0001	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Pre	
				8/27/2020 4:0	
		Title XIX	Hospi tal	Cost	
			Inpatient 1.00	Outpatient 2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	LCES FOR TITLES V OR		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpati ent hospital/SNF/NF services		331, 455		1 1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		331, 455	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		331, 455	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
~~	Reasonable Charges		442.000		
00	Routi ne servi ce charges		442,090	0	8
. 00	Ancillary service charges Organ acquisition charges, net of revenue		593, 970 0	0	10
I. 00	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		1, 036, 060	0	12
00	CUSTOMARY CHARGES		1,030,000	0	1 12
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13
	basi s	3			
. 00	Amounts that would have been realized from patients liable for	payment for services of	on 0	0	14
	a charge basis had such payment been made in accordance with 42	2 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15
b. 00	Total customary charges (see instructions)		1, 036, 060	0	
7.00	Excess of customary charges over reasonable cost (complete only	/ifline 16 exceeds	704, 605	0	17
	line 4) (see instructions)				
3. 00	Excess of reasonable cost over customary charges (complete only	/ If line 4 exceeds lii	ne 0	0	18
9.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
). 00	Cost of physicians' services in a teaching hospital (see instru	ictions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line 16		331, 455	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o			0	1 2 1
2.00	Other than outlier payments		0	0	22
	Outlier payments		0	0	
I. 00	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0		25
b. 00	Routine and Ancillary service other pass through costs		0	0	26
7.00	Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		331, 455	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		331, 455	0	
. 00	Deducti bl es Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	331, 455	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	/	0	0	
3.00	Subtotal (line 36 $\pm$ line 37)		331, 455	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39
-	Total amount payable to the provider (sum of lines 38 and 39)		331, 455	0	
. 00				0	
	Interim payments		627, 727	0	41
0.00 1.00 2.00	Interim payments Balance due provider/program (line 40 minus line 41)		-296, 272	0	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0001	Period: From 01/01/2019 To 12/31/2019		
		General Fund	Specific Purpose Fun		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	1, 613, 673		0 0	0	1.00
. 00	Temporary investments	0		0 0	0	2.00
. 00	Notes receivable	0		0 0	-	3.00
. 00	Accounts receivable	8, 739, 894		0 0	0	4.00
. 00 . 00	Other receivable Allowances for uncollectible notes and accounts receivable	3, 117, 628		0 0	0	5.00 6.00
. 00	Inventory	2, 107, 329		0 0	0	7.00
. 00	Prepai d expenses	61, 788, 691		0 0	0	
. 00	Other current assets	161, 694		0 0	0	9.00
0.00	Due from other funds	0		0 0	-	10.00
1.00	Total current assets (sum of lines 1-10)	77, 528, 909		0 0	0	11.00
2.00	FI XED ASSETS Land	4, 743, 426		0 0	0	12.00
3.00	Land improvements	2, 880, 819		0 0	-	13.00
	Accumulated depreciation	-1, 422, 184		0 0	0	
5.00	Buildings	68, 523, 048		0 0	0	15.00
6.00	Accumulated depreciation	-29, 401, 644		0 0	0	16.00
7.00	Leasehold improvements	0		0 0	0	
8.00	Accumulated depreciation	0		0 0	0	18.00
	Fixed equipment	13, 108, 408		0 0	0	19.00
0.00 1.00	Accumulated depreciation Automobiles and trucks	-11, 417, 415		0 0	0	20.00
	Accumulated depreciation	0		0 0	0	
	Major movable equipment	92, 382, 840		0 0	0	23.00
	Accumulated depreciation	-38, 686, 315	1	0 0	0	24.00
5.00	Minor equipment depreciable	0		0 0	0	25.00
6.00	Accumulated depreciation	0		0 0	0	26.00
	HIT designated Assets	0		0 0	0	27.00
8.00 9.00	Accumulated depreciation	0		0 0	-	28.00
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	100, 710, 983		0 0 0 0		
0.00	OTHER ASSETS	100, 110, 100	1		, <u> </u>	00.00
1.00	Investments	71, 375		0 0	0	31.00
2.00	Deposits on Leases	0		0 0	-	
3.00	Due from owners/officers	0		0 0	0	33.00
4.00 5.00	Other assets	32, 729, 539 32, 800, 914		0 0	0	34.00 35.00
5.00 6.00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	211, 040, 806		0 0		35.00
0.00	CURRENT LI ABI LI TI ES	211,010,000	1	<u> </u>	<u> </u>	00.00
7.00	Accounts payable	6, 832, 525		0 0	0	37.00
8.00	Salaries, wages, and fees payable	4, 464, 371		0 0		•
9.00	Payroll taxes payable	889, 588		0 0	0	
	Notes and Loans payable (short term)	0		0 0		40.00
1.00 2.00	Deferred income Accelerated payments	0		0 0	0	41.00
3.00	Due to other funds	0		0 0	0	
4.00	Other current liabilities	-333, 247		0 0		
	Total current liabilities (sum of lines 37 thru 44)	11, 853, 237		0 0		
	LONG TERM LIABILITIES					
6.00	Mortgage payable	0		0 0		
7.00	Notes payable	15, 948, 204		0 0	-	
8.00 9.00	Unsecured loans Other long term liabilities	0			0	48.00 49.00
0.00	Total long term liabilities (sum of lines 46 thru 49)	15, 948, 204		0 0		50.00
	Total liabilities (sum of lines 45 and 50)	27, 801, 441	1	0 0		51.00
	CAPITAL ACCOUNTS					
2.00	General fund balance	183, 239, 365				52.00
3.00	Specific purpose fund			0		53.00
4.00	Donor created - endowment fund balance - restricted			0		54.00
5.00 6.00	Donor created - endowment fund balance - unrestricted			0		55.00 56.00
6.00 7.00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56.00
7.00 8.00	Plant fund balance - reserve for plant improvement,				0	
5.00	replacement, and expansion					30.00
9.00	Total fund balances (sum of lines 52 thru 58)	183, 239, 365		0 0	0	59.00
0.00	Total liabilities and fund balances (sum of lines 51 and	211, 040, 806	1		0	60.0

STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0001	Period: From 01/01/2019	Worksheet G-	
	General	Fund	Special F	To 12/31/2019 Purpose Fund	Date/Time Pr 8/27/2020 4: Endowment Fund	
	1.00	0.00		1.00		
1.00 Fund balances at beginning of period	1.00	2.00 171,923,632	3.00	4.00	5.00	1.00
1.00 Full barances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) 5.00 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 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 183, 239, 365				$\begin{array}{c} 1. 00\\ 2. 00\\ 3. 00\\ 0 & 4. 00\\ 0 & 5. 00\\ 0 & 6. 00\\ 0 & 7. 00\\ 0 & 8. 00\\ 0 & 9. 00\\ 10. 00\\ 11. 00\\ 0 & 12. 00\\ 0 & 13. 00\\ 0 & 14. 00\\ 0 & 15. 00\\ 0 & 16. 00\\ 0 & 17. 00\\ 18. 00\\ \end{array}$
19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment	183, 239, 365 Pl ant	Fund	0		19.00
	Fund			_		
	6.00	7.00	8.00			
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)3.00Total (sum of line 1 and line 2)4.00Additions (credit adjustments) (specify)5.006.007.008.009.009.00	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
<ul> <li>10.00 Total additions (sum of line 4-9)</li> <li>11.00 Subtotal (line 3 plus line 10)</li> <li>12.00 Deductions (debit adjustments) (specify)</li> <li>13.00</li> <li>14.00</li> <li>15.00</li> <li>16.00</li> <li>17.00</li> <li>18.00 Total deductions (sum of lines 12-17)</li> </ul>	000	0 0 0 0 0 0		000		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00

MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0001	Peri od: From 01/01/2019 To 12/31/2019	Worksheet G-2 Parts I & II Date/Time Pre 8/27/2020 4:0	parec
Cost Center Description		I npati ent	Outpati ent	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					-
General Inpatient Routine Services		10 700 0		10 700 001	
Hospi tal		12, 738, 08	34	12, 738, 084	1.0
SUBPROVIDER - IPF				0	2.0
SUBPROVIDER - IRF			0	0	
SUBPROVI DER			0	0	4.0
Swing bed - SNF Swing bed - NF			0	0	
SKILLED NURSING FACILITY			0	0	7.0
NURSING FACILITY					8.0
OTHER LONG TERM CARE					9.0
Total general inpatient care services (sum of lines 1-9	n)	12, 738, 08	24	12, 738, 084	
Intensi ve Care Type Inpatient Hospital Services	)	12, 730, 00	04	12, 730, 004	10.
INTENSIVE CARE UNIT		1, 297, 33	25	1, 297, 335	111.
CORONARY CARE UNIT		1,277,00	,5	1, 277, 333	12.
BURN I NTENSI VE CARE UNI T					13.
SURGI CAL I NTENSI VE CARE UNI T					14.
OTHER SPECIAL CARE (SPECIFY)					15.
Total intensive care type inpatient hospital services ( 11-15)	sum of lines	1, 297, 33	35	1, 297, 335	
Total inpatient routine care services (sum of lines 10	and 16)	14, 035, 4	0	14,035,419	17.
Ancillary services		38, 021, 05		186, 351, 226	
Outpatient services		4, 049, 52		46, 305, 819	
RURAL HEALTH CLINIC		1,017,02	0 0	0,000,017	20.
FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.
HOME HEALTH AGENCY			1, 158, 497	1, 158, 497	
AMBULANCE SERVICES			.,,	.,,	23.
CMHC					24.
AMBULATORY SURGICAL CENTER (D. P. )					25.
HOSPICE					26.
NRCC			0 109, 750	109, 750	27.
PRO FEES			0 14, 096, 403	14,096,403	
OTHER			0 0	0	27.
Total patient revenues (sum of lines 17-27)(transfer co G-3, line 1)	lumn 3 to Wkst.	56, 105, 99	205, 951, 117	262, 057, 114	28.
PART II - OPERATING EXPENSES					
Operating expenses (per Wkst. A, column 3, line 200)			89, 371, 516		29.
ADD (SPECI FY)			0		30.
			0		31.
			0		32.
			0		33.
			0		34.
			0		35.
Total additions (sum of lines 30-35)			0		36.
DEDUCT (SPECIFY)			0		37.
			0		38.
			0		39.
			0		40.
			0		41.
Total deductions (sum of lines 37-41)			0		42.
Total operating expenses (sum of lines 29 and 36 minus to Wkst. G-3, line 4)	line 42)(transfer		89, 371, 516		43.

Heal th Fina	ncial Systems	JOHNSON MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
STATEMENT C	F REVENUES AND EXPENSES		Provider CCN: 15-0001	Period:	Worksheet G-3	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
				10 12/31/2017	8/27/2020 4:0	
					1.00	
	patient revenues (from Wkst.				262, 057, 114	1.00
	contractual allowances and di	•	ts		177, 754, 135	2.00
	patient revenues (line 1 minus				84, 302, 979	3.00
	total operating expenses (fro		43)		89, 371, 516	4.00
	income from service to patient	s (line 3 minus line 4)			-5, 068, 537	5.00
	RINCOME			1		
	ributions, donations, bequests	, etc			0	6.00
	me from investments				0	7.00
	nues from telephone and other		servi ces		0	8.00
	nue from television and radio	servi ce			0	9.00
	nase di scounts				0	10.00
	tes and refunds of expenses				0	11.00
	ing lot receipts				0	12.00
	nue from laundry and linen ser				0	13.00
14.00 Reve	nue from meals sold to employe	es and guests			0	14.00
	nue from rental of living quar				0	15.00
	nue from sale of medical and s		han patients		0	16.00
17.00 Reve	nue from sale of drugs to othe	r than patients			0	17.00
18.00 Reve	nue from sale of medical recor	ds and abstracts			0	18.00
19.00 Tui t	ion (fees, sale of textbooks,	uniforms, etc.)			0	19.00
20.00 Reve	nue from gifts, flowers, coffe	e shops, and canteen			0	20.00
21.00 Rent	al of vending machines				0	21.00
22.00 Rent	al of hospital space				0	22.00
23.00 Gove	rnmental appropriations				0	23.00
24.00 OTHE	RINCOME				526, 444	24.00
24.01 NON-	OPERATING INCOME				1, 138, 517	24.01
24.02 UPL	INCOME				14, 716, 904	24.02
24.03 REON	CILING ITEM				2, 405	24.03
25.00 Tota	l other income (sum of lines 6	-24)			16, 384, 270	25.00
26.00 Tota	(line 5 plus line 25)				11, 315, 733	26.00
27.00 OTHE	R EXPENSES (SPECIFY)				0	27.00
28.00 Tota	other expenses (sum of line	27 and subscripts)			0	28.00
29.00 Net	income (or loss) for the perio	d (line 26 minus line 28)			11, 315, 733	29.00

Heal th	Financial Systems		JOHNSON MEMORI	AL_HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ANALYS	IS OF HOSPITAL-BASED HOME HEALT	TH AGENCY COSTS	,	Provider C	F	Period: From 01/01/2019	Worksheet H	
				HHA CCN:	15-7510 T	o 12/31/2019	Date/Time Pre 8/27/2020 4:0	
						Home Health Agency I	PPS	
		Sal ari es	Employee Benefits	Transportatio n (see	Contracted/Pu rchased		Total (sum of cols. 1 thru	
		1.00		instructions)	Servi ces	5.00	5)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable			0		0	0	2.00
3.00	Equipment Plant Operation & Maintenance	0	0	0	c	0	0	3.00
4.00 5.00	Transportation Administrative and General	0 176, 862	0	0 35, 902	-		0 278, 794	
	HHA REIMBURSABLE SERVICES				1	· · ·		
6.00 7.00	Skilled Nursing Care Physical Therapy	210, 974 118, 567		0 0			210, 974 118, 567	
8.00 9.00	Occupational Therapy Speech Pathology	83, 242 0	0	0	-		83, 242 0	
10.00	Medical Social Services	99	0	0	C	0	99	10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	30, 864 0	0	0	-	-	30, 864 10, 996	
13.00 14.00	Drugs	0	0	0			0	13.00
14.00	HHA NONREI MBURSABLE SERVI CES	0						14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	-	0	-	-	0	
17.00	Private Duty Nursing	0	0	0	-	-	0	17.00
18.00 19.00	Clinic Health Promotion Activities	0	0	0 0	-		0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0	C	-	0	
21.00	Homemaker Service	0	0	0	C	, s	0	22.00
23.00 23.50	All Others (specify) Telemedicine	0	0	0			0	
	Total (sum of lines 1-23)	620, 608		35, 902	C	-	733, 536	
		Reclassi fi cat i on	Reclassified Trial Balance	Adjustments	Net Expenses for			
			(col. 6 + col.7)		Allocation (col. 8 +			
		7.00	8.00	9.00	<u>col. 9)</u> 10.00	-		-
	GENERAL SERVICE COST CENTERS				1			
1.00	Capital Related - Bldg. & Fixtures	0	0	0	C	)		1.00
2.00	Capital Related - Movable Equipment	0	0	0	C			2.00
3.00	Plant Operation & Maintenance	0	0	0				3.00
4.00 5.00	Transportation Administrative and General	0	0 278, 794	0 0				4.00 5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	-11, 490	199, 484	0	199, 484			6.00
7.00	Physical Therapy	0	118, 567	0	118, 567			7.00
8.00 9.00	Occupational Therapy Speech Pathology	0	83, 242 0	0				8.00 9.00
10.00	Medical Social Services	0	99	0				10.00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	0	30, 864 10, 996	0 0				11.00 12.00
13.00 14.00	Drugs DME	0	0 0	0				13.00 14.00
	HHA NONREI MBURSABLE SERVI CES				1			
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0		0 0				15.00 16.00
17.00	Private Duty Nursing	0	0	0	C			17.00
18.00 19.00	Clinic Health Promotion Activities	0	0	0 0	-			18.00 19.00
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0				20.00 21.00
22.00	Homemaker Service	0	0	0	C			22.00
	All Others (specify) Telemedicine	0	0	0 0				23.00 23.50
	Total (sum of lines 1-23)	-11, 490	722, 046	0	-			24.00

Heal th	Financial Systems		JOHNSON MEMORIA	AL HOSPLTAL		Inlie	u of Form CMS-2	2552-10
	LLOCATION - HHA GENERAL SERVICE	E COST		Provi der C	CN: 15-0001	Period:	Worksheet H-1	
				HHA CCN:	15-7510	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
						Home Health	8/27/2020 4:0 PPS	1 pm
						Agency I		
			Capital Rela	ated Costs				
		Net Expenses	BI dgs &	Movabl e	Plant	Transportatio	Subtotal	1
		for Cost Allocation	Fi xtures	Equi pment	Operation & Maintenance		(cols. 0-4)	
		(from Wkst.						
		H, col. 10) 0	1.00	2.00	3.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS				1		1	
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable	0		0			0	2.00
3.00	Equipment Plant Operation & Maintenance	0	О	0		0	0	3.00
4.00	Transportation	0	0	0	1	0 0		4.00
5.00	Administrative and General HHA REIMBURSABLE SERVICES	278, 794	0	0	1	0 0	278, 794	5.00
6.00	Skilled Nursing Care	199, 484	0	0	1	0 0		•
7.00 8.00	Physical Therapy Occupational Therapy	118, 567 83, 242	0	0		0 0	118, 567 83, 242	•
9.00	Speech Pathology	0	0	0		0 0	0	9.00
10.00 11.00	Medical Social Services Home Health Aide	99 30, 864	0	0		0 0	99 30, 864	•
12.00	Supplies (see instructions)	10, 996	Ő	0		0 0	10, 996	12.00
13.00 14.00	Drugs DME	0	0	0 0		0 0	0	
14.00	HHA NONREI MBURSABLE SERVI CES			0				14.00
15.00 16.00	Home Dialysis Aide Services Respiratory Therapy	0	0	0	1			
17.00	Private Duty Nursing	0	0	0		0 0	-	
18.00	Clinic	0	0	0			0	
19.00 20.00	Health Promotion Activities Day Care Program	0	0	0		0 0	0	
21.00	Home Delivered Meals Program	0	0	0		0 0	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0	0		0 0	0	
23.50	Tel emedi ci ne	0	0	0		0 0	-	23.50
24.00	Total (sum of lines 1-23)	722,046 Administrativ	0 Total (cols.	0	1	0 0	722, 046	24.00
		e & General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5.00	6.00					
1.00	Capital Related - Bldg. &							1.00
2.00	Fixtures Capital Related - Movable							2.00
	Equi pment							
3.00 4.00	Plant Operation & Maintenance Transportation							3.00 4.00
5.00	Administrative and General	278, 794						5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	125, 470	324, 954					6.00
7.00	Physical Therapy	74, 576	193, 143					7.00
8.00 9.00	Occupational Therapy Speech Pathology	52, 357 0	135, 599 0					8.00 9.00
10.00	Medical Social Services	62	161					10.00
11.00 12.00	Home Health Aide Supplies (see instructions)	19, 413 6, 916	50, 277 17, 912					11.00
13.00	Drugs	0, 710	0					13.00
14.00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14.00
15.00		0	0					15.00
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0					16.00 17.00
17.00		0	0					17.00
19.00	Health Promotion Activities	0	o					19.00
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0					20.00 21.00
22.00	Homemaker Service	0	0					22.00
23.00 23.50		0	0					23.00 23.50
	Total (sum of lines 1-23)		722, 046					24.00

Heal th	Financial Systems		JOHNSON MEMORI	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - HHA STATISTICAL BAS	SES		Provider C HHA CCN:		Period: From 01/01/2019 To 12/31/2019	Worksheet H-1 Part II	pared:
						Home Health Agency I	PPS	_ <b>-</b>
		Capital Rel	ated Costs					
		BI dgs & Fi xtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Pl ant Operation & Maintenance (SQUARE FEET)	Transportation n (MILEAGE)	Reconciliatio n	Administrativ e & 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	0		0		3.00
4.00	Transportation (see	0	0	0		0		4.00
	instructions)							
5.00	Administrative and General	0	0	0		0 -278, 794	443, 252	5.00
	HHA REIMBURSABLE SERVICES				1		100.101	
6.00	Skilled Nursing Care	0	0	0		0 0	,	6.00
7.00 8.00	Physical Therapy Occupational Therapy	0	0	0		0 0	118, 567	7.00 8.00
8.00 9.00	Speech Pathology	0	0	0			83, 242	9.00
10.00	Medical Social Services	0	0				99	
11.00	Home Heal th Ai de	0	0	0				11.00
12.00	Supplies (see instructions)	0	0	0		0 0		12.00
13.00	Drugs	0	0	0		0	0	
	DME	0	0	0		0 0	0	
	HHA NONREI MBURSABLE SERVI CES					-		
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	15.00
16.00	Respiratory Therapy	0	0	0		0 0	0	
	Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
	Health Promotion Activities	0	0	0		0 0	0	
20.00	Day Care Program	0	0	0		0 0	0	20.00
	Home Delivered Meals Program	0	0	0		0 0	0	
22.00 23.00	Homemaker Service All Others (specify)	0	0				0	
23.00 23.50	Telemedicine	0	0				0	23.00
	Total (sum of lines 1-23)	0	0			0 -278, 794		
25.00	Cost To Be Allocated (per	0	0	0		0	278, 794	
26.00	Worksheet H-1, Part I) Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0.00000	0	0. 628974	26.00

LOCATION OF GENERAL SERVICE COSTS -	TO HHA COST CEN	TERS	Provider CO	CN 15-0001 P	eri od:	Worksheet H-2	
ECONTION OF GENERAL SERVICE COSTS		TERS	HHA CCN:	F	rom 01/01/2019 o 12/31/2019	Part I	pare
					Home Health	PPS	
		CAPI TAL REL	ATED COSTS		Agency I		
Cost Center Description	HHA Trial Balance (1)	NEW BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ON S	DATA PROCESSI NG	
	0	1.00	2.00	4.00	4. 01	4.02	
00 Administrative and General	0	0	97	174, 094	6, 307	55, 888	
00 Skilled Nursing Care 00 Physical Therapy	324, 954 193, 143	0	0	0	0	0	2. 3.
00 Occupational Therapy	135, 599	0	0	0	0	0	4.
00 Speech Pathology	0	0	0	0	0	0	5.
00 Medical Social Services	161	0	0	0	0	0	6.
00 Home Health Aide	50, 277	0	0	0	0	0	7.
00 Supplies (see instructions) 00 Drugs	17, 912	0	0	0	0	0	
. 00 DH USS	0	0	0	0	0	0	
.00 Home Dialysis Aide Services	0	0	0	0	0	0	
. 00 Respiratory Therapy	0	0	0	0	0	0	12.
.00 Private Duty Nursing	0	0	0	0	0	0	
.00 Clinic	0	0	0	0	0	0	
.00 Health Promotion Activities .00 Day Care Program	0	0	0	0	0	0	
. 00 Home Delivered Meals Program	0	0	0	0	0	0	
. 00 Homemaker Service	0	0	0	0	0	0	
00 All Others (specify)	0	0	0	0	0	0	19.
. 50 Tel emedi ci ne	0	0	0	0	0	0	
<ul> <li>00 Total (sum of lines 1-19) (2)</li> <li>00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.</li> </ul>	722, 046	0	97	174, 094	6, 307	55, 888	20. 21.
Cost Center Description	MATERIALS MANAGEMENT	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	
	4.03	4.04	4.05	4A. 05	5.00	7.00	
00 Administrative and General 00 Skilled Nursing Care	2,006	4, 839	9, 745 0	252, 976 324, 954		20, 838 0	
00 Physical Therapy	0	0	0	193, 143		0	3
00 Occupational Therapy	0	0	0	135, 599		0	4
00 Speech Pathology	0	0	0	0	0	0	5
00 Medical Social Services	0	0	0	161		0	6
00 Home Health Aide 00 Supplies (see instructions)	0	0	0	50, 277 17, 912		0	7
00 Drugs	0	0	0	17, 912	2,229	0	
OO DME	0	0	0	0	0	0	
00 Home Dialysis Aide Services	0	0	0	0	0	0	11
00 Respiratory Therapy	0	0	0	0	0	0	
00 Private Duty Nursing 00 Clinic	0	0	0	0	0	0	
00 Clinic 00 Health Promotion Activities	0	0	0	0	0	0	
00 Day Care Program	0	0	0	0	0	0	
00 Home Delivered Meals Program	0	0	0	0	0	0	
00 Homemaker Service	0	0	0	0	0	0	
00 All Others (specify)	0	0	0	0	0	0	
50 Telemedicine 00 Total (sum of lines 1-19) (2)	2,006	0 4, 839	0 9, 745	0 975, 022	0 121, 353	0 20, 838	
<ul> <li>00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.</li> </ul>	2,000	4, 039	7, 743	0. 000000		20, 030	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.

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS	TO HHA COST CEN	ITERS	Provider CC	CN: 15-0001 15-7510	Period: From 01/01/2019 To 12/31/2019 Home Health		pared:
Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	Agency I NURSING ADMINISTRATIO N	CENTRAL SERVI CES & SUPPLY	
	8.00	9.00	10. 00	11.00	13.00	14.00	
<ol> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>Constant</li> <li>Skilled Nursing Care</li> <li>Skilled Nursing Care</li> <li>Constant</li> <li>Con</li></ol>			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		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
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		Allocated HHA A&G (see Part II)	
	15.00	16.00	24.00	25.00	26.00	27.00	
<ol> <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 Health Promotion Activities</li> <li>16.00 Day Care Program</li> <li>17.00 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 Total (sum of lines 1-19) (2)</li> <li>21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.</li> </ol>			332, 318 365, 398 217, 182 152, 476 0 181 56, 535 20, 141 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		$ \begin{smallmatrix} 0 & 332, 318 \\ 0 & 365, 398 \\ 0 & 217, 182 \\ 0 & 152, 476 \\ 0 & 0 \\ 0 & 181 \\ 0 & 56, 535 \\ 0 & 20, 141 \\ 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 \\ 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 \\ 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 \\ 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 \\ 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 \\$	149, 558 88, 893 62, 409 0 74 23, 140 8, 244 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 19.00 19.50 20.00

(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.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS         Provider CCN: 15-001 HA CCN:         Provider CCN: 15-001 To 12/31/2019 To 12/3	Heal th	Financial Systems		JOHNSON MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HHA CCN:         15-7510         To         12/31/2019         Date/Time Prepared: 8/27/2020           Cost Center Description         Total HHA Costs         Ha         Cost         Home Heal th Agency I         PPS           1.00         Administrative and General 28.00         28.00         1.00         Administrative and General 28.00         2.00         1.00         Administrative and General 29.00         2.00         Skilled Nursing Care 3.00         514,956         2.00           0.00         Occupational Therapy 4.00         206,075         3.00         4.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         5.00         6.00         7.00	ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider (	CCN: 15-0001			
Cost Center Description         Total HHA Costs         Hame Heal th Agency I         PPS           1.00         Administrative and General 2.00         5killed Nursing Care 306, 075         1.00         1.00         2.00         1.00         2.00         1.00         2.00         3.00           4.00         Occupational Therapy 5.00         214,885         2.00         3.00         4.00         2.00         4.00         2.00         4.00         5.00         9.00         5.00         9.00         5.00         9.00         5.00         9.00         5.00         9.00         5.00         9.00         5.00         9.00         5.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00         9.00						15 7510			narod
Cost Center Description         Total HHA Costs         PPS           1.00         Administrative and General 28.00         1.00         1.00         1.00           2.00         Skilled Nursing Care 3.00         514,956         1.00           3.00         Physical Therapy         214,885         2.00           5.00         Speech Pathology         0         4.00           6.00         Medical Social Services         255         6.00           7.00         Home Healt h ide         79,675         8.00           9.00         Drugs         0         10.00           9.00         Drugs         0         10.00           10.00         Mem Evalt h Aide         79,675         8.00           9.00         Drugs         0         10.00           10.00         Mem Evalt hPromotion Activities         0         11.00           11.00         Home Bealt hPromotion Activities         0         11.00           11.00         Divide Duty Nursing         0         12.00           12.00         Private Duty Nursing         0         14.00           13.00         Private Duty Nursing         0         15.00           16.00         Day Care Program         0					HHA CON.	15-7510	10 12/31/2019		
Cost Center Description         Total HHA Costs         Image: Cost Cost Cost Cost Cost Cost Cost Cost							Home Health		
Costs         28.00           1.00         Administrative and General         1.00           2.00         Skilled Nursing Care         514,956           3.00         Physical Therapy         306,075           4.00         Occupational Therapy         214,885           5.00         Speech Pathology         0           6.00         Medical Social Services         255           7.00         Home Health Aide         79,675           8.00         Supplies (see instructions)         28,385           9.00         Drugs         0           10.00         ME         0           11.00         Home Dialysis Aide Services         0           11.00         Respiratory Therapy         0           11.00         Meme Dialysis Aide Services         0           11.00         Home Dialysis Aide Services         0           11.00         Home Dialysis Aide Services         0           12.00         Respiratory Therapy         0           13.00         Private Duty Nursing         0           14.00         Clinic         0           15.00         Heal th Promotion Activities         0           16.00         Day Care Program         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Agency I</td> <td></td> <td></td>							Agency I		
28.00           1.00         Administrative and General         1.00           2.00         Skilled Nursing Care         514,956           3.00         Physical Therapy         306,075           4.00         Occupational Therapy         214,885           5.00         Speech Pathology         4.00           6.00         Medical Social Services         255           7.00         Home Heal th Aide         79,675           8.00         Supplies (see instructions)         28,385           9.00         Drugs         0           10.00         DME         0           11.00         Home Dialysis Aide Services         0           12.00         Respiratory Therapy         0           13.00         Private Duty Nursing         0           14.00         Clinic         0           15.00         Heal th Promotion Activities         0           16.00         Day Care Program         0           17.00         Home Delivered Meals Program         0 <td></td> <td>Cost Center Description</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		Cost Center Description							
1.00       Administrative and General       1.00         2.00       Skilled Nursing Care       514,956         3.00       Physical Therapy       306,075         4.00       Occupational Therapy       214,885         5.00       Speech Pathology       0         6.00       Medical Social Services       255         7.00       Home Heal th Ai de       79,675         8.00       Supplies (see instructions)       28,385         9.00       Drugs       0         10.00       DME       0         11.00       Home Bial ysis Ai de Services       0         11.00       Borg Therapy       0         11.00       DWE       0         11.00       DWE       0         11.00       Respiratory Therapy       0         12.00       Respiratory Therapy       0         13.00       Private Duty Nursing       0         14.00       Clinic       0         15.00       Heal th Promotion Activities       0         16.00       Day Care Program       0         17.00       Home Bale S Program       0         18.00       Homemaker Service       0         19.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>									
2.00       Skilled Nursing Care       514,956       2.00         3.00       Physical Therapy       306,075       3.00         4.00       Occupational Therapy       214,885       4.00         5.00       Speech Pathology       0       6.00         6.00       Medical Social Services       255       6.00         7.00       Home Healt Aide       79,675       7.00         8.00       Supplies (see instructions)       28,385       8.00         9.00       Drugs       0       9.00         10.00       DME       0       10.00         11.00       Home Pailysis Aide Services       0       11.00         12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       12.00         14.00       Clinic       0       14.00         15.00       Health Promotion Activities       0       15.00         16.00       Day Care Program       0       16.00         17.00       Homemaker Service       0       18.00         19.00       All Others (specify)       0       19.00         19.00       Tel emedicine       0       19.00 <td< td=""><td></td><td></td><td>28.00</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>			28.00						
3.00       Physical Therapy       306,075       3.00         4.00       Occupational Therapy       214,885       4.00         5.00       Speech Pathology       0       5.00         6.00       Medical Social Services       255       5.00         7.00       Home Health Aide       79,675       7.00         8.00       Supplies (see instructions)       28,385       9.00         9.00       Drugs       0       10.00         11.00       Home Dial ysis Aide Services       0       10.00         12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       14.00         15.00       Healt th Promotion Activities       0       14.00         16.00       Day Care Program       0       14.00         17.00       Home Beli vered Meals Program       0       15.00         18.00       Homedials Service       0       19.00         19.00       All Others (specify)       0       19.00         19.00       All Others (specify)       0       19.00         19.00       Telemedicine       0       20.00									
4.00       Occupational Therapy       214,885       4.00         5.00       Speech Pathology       0       5.00         6.00       Medical Social Services       255       6.00         7.00       Home Health Aide       79,675       7.00         8.00       Supplies (see instructions)       28,385       8.00         9.00       Drugs       0       10.00         11.00       Home Dialysis Aide Services       0       10.00         11.00       Home Dialysis Aide Services       0       11.00         12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       14.00         15.00       Health Promotion Activities       0       15.00         16.00       Day Care Program       0       17.00         18.00       Homemaker Service       0       18.00         19.00       All Others (specify)       0       19.00         19.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column 26, line 1, rounded to       21.00       21.00		ũ							
5.00       Speech Pathology       0       5.00         6.00       Medical Social Services       255       6.00         7.00       Home Health Aide       79,675       7.00         8.00       Supplies (see instructions)       28,385       8.00         9.00       Drugs       0       9.00         10.00       DME       0       10.00         11.00       Home Dialysis Aide Services       0       11.00         12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       13.00         15.00       Health Promotion Activities       0       14.00         15.00       Home Delivered Meals Program       0       15.00         18.00       Home Delivered Meals Program       0       17.00         19.00       All Others (specify)       0       19.00         19.00       All Others (specify)       0       19.00         19.00       All Others (specify)       0       19.00         19.00       11.01 vivided by the sum of column 26, line 1 vivided by the sum of column 26, line 20 minus column 26, line 20 minus column 26, line 20 minus       21.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
6.00       Medical Social Services       255       6.00         7.00       Home Heal th Ai de       79,675       7.00         8.00       Supplies (see instructions)       28,385       8.00         9.00       Drugs       0       9.00         10.00       DME       0       10.00         11.00       Home Dialysis Ai de Services       0       11.00         12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       14.00         15.00       Heal th Promotion Activities       0       15.00         16.00       Day Care Program       0       15.00         17.00       Home Meaker Service       0       17.00         18.00       Homemaker Service       0       18.00         19.00       All Others (specify)       0       19.00         19.50       Tel emedicine       0       19.50         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column 26, line 1, rounded to       21.00		1 13							
7.00       Home Heal th Aide       79,675       7.00         8.00       Supplies (see instructions)       28,385       8.00         9.00       Drugs       0       9.00         10.00       DME       10.00       10.00         11.00       Home Dialysis Aide Services       0       11.00         12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       15.00         15.00       Heal th Promotion Activities       0       15.00         16.00       Day Care Program       0       16.00         17.00       Home Delivered Meals Program       0       17.00         18.00       Homemaker Service       0       19.00         19.00       All Others (specify)       0       19.00         19.50       Tel emedicine       0       19.00         20.00       Total (sum of lines 1-19) (2)       1, 144, 231       20.00         21.00       Line 1 divided by the sum of column 26, line 1, rounded to       1, 144, 231       21.00									
8.00       Supplies (see instructions)       28,385       8.00         9.00       Drugs       0       9.00         10.00       DME       0       10.00         11.00       Home Dialysis Aide Services       0       11.00         12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       14.00         15.00       Heal th Promotion Activities       0       16.00         16.00       Day Care Program       0       16.00         17.00       Home Delivered Meals Program       0       17.00         18.00       Homemaker Service       0       19.00         19.00       All Others (specify)       0       19.00         19.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       uit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to       21.00									
9.00       Drugs       9.00         10.00       DME       10.00         11.00       Home Dialysis Aide Services       0         12.00       Respiratory Therapy       0         13.00       Private Duty Nursing       0         14.00       Clinic       14.00         15.00       Health Promotion Activities       0         16.00       Day Care Program       0         17.00       Home Delivered Meals Program       0         18.00       Homemaker Service       0         19.00       All Others (specify)       0         19.50       Tel emedicine       0         20.00       Total (sum of lines 1-19) (2)       1, 144, 231         21.00       unt 26, line 1, rounded to       21.00									
10.00       DME       10.00         11.00       Home Dialysis Aide Services       0         12.00       Respiratory Therapy       0         13.00       Private Duty Nursing       0         14.00       Clinic       13.00         15.00       Heal th Promotion Activities       0         16.00       Day Care Program       0         17.00       Home Delivered Meals Program       0         18.00       Homemaker Service       0         19.00       All Others (specify)       0         19.50       Tel emedicine       0         20.00       Total (sum of lines 1-19) (2)       1, 144, 231         21.00       Unit Cost Multiplier: column       21.00         21.00       Unit Cost Multiplier: column       21.00         21.00       Column 26, line 1, rounded to       21.00			28, 385						
11.00       Home Dialysis Aide Services       0       11.00         12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       14.00         15.00       Heal th Promotion Activities       0       15.00         16.00       Day Care Program       0       16.00         17.00       Homemaker Service       0       17.00         18.00       Homemaker Service       0       18.00         19.00       All Others (specify)       0       19.00         19.50       Tel emedicine       0       19.50         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column       2, line 1 divided by the sum of column 26, line 1, rounded to       21.00			0						
12.00       Respiratory Therapy       0       12.00         13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       14.00         15.00       Heal th Promotion Activities       0       14.00         16.00       Day Care Program       0       15.00         16.00       Day Care Program       0       16.00         17.00       Home Delivered Meals Program       0       17.00         18.00       Homemaker Service       0       18.00         19.00       All Others (specify)       0       19.00         19.50       Tel emedicine       0       19.50         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column       26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to       21.00			0						
13.00       Private Duty Nursing       0       13.00         14.00       Clinic       0       14.00         15.00       Heal th Promotion Activities       0       15.00         16.00       Day Care Program       0       16.00         17.00       Home Delivered Meals Program       0       16.00         18.00       Homemaker Service       0       17.00         19.00       All Others (specify)       0       19.00         19.50       Tel emedicine       0       19.50         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column       26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to       21.00			0						
14.00       Clinic       0       14.00         15.00       Heal th Promotion Activities       0       15.00         16.00       Day Care Program       0       16.00         17.00       Home Delivered Meals Program       0       17.00         18.00       Homemaker Service       0       17.00         19.00       All Others (specify)       0       19.00         19.50       Tel emedicine       0       19.50         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column       26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to       21.00			0						
15.00       Heal th Promotion Activities       0       15.00         16.00       Day Care Program       0       16.00         17.00       Home Delivered Meals Program       0       17.00         18.00       Homemaker Service       0       18.00         19.00       All Others (specify)       0       19.00         19.50       Telemedicine       0       19.00         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to       1			0						
16.00Day Care Program016.0017.00Home Delivered Meals Program017.0018.00Homemaker Service018.0019.00All Others (specify)019.0019.50Telemedicine019.5020.00Total (sum of lines 1-19) (2)1,144,23120.0021.00Unit Cost Multiplier: column21.0026, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to1			0						
17.00       Home Delivered Meals Program       0       17.00         18.00       Homemaker Service       0       18.00         19.00       All Others (specify)       0       19.00         19.50       Telemedicine       0       19.00         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column       21.00       21.00         26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to       1       1		1	0						
18.00       Homemaker Service       0       18.00       18.00         19.00       All Others (specify)       0       19.00         19.50       Tel emedicine       0       19.50         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column       26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to       21.00			0						
19.00       All Others (specify)       0       19.00         19.50       Telemedicine       0       19.50         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to       1		5	0						
19.50       Telemedicine       0       19.50         20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00         21.00       Unit Cost Multiplier: column       26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to       21.00		1	0						
20.00       Total (sum of lines 1-19) (2)       1,144,231       20.00       21.00         21.00       Unit Cost Multiplier: column       26, line 1 divided by the sum       21.00       21.00         26, line 1 divided by the sum       of column 26, line 20 minus       column 26, line 1, rounded to       21.00	19.00		0						
21.00       Unit Cost Multiplier: column       21.00         26, line 1 divided by the sum       of column 26, line 20 minus       21.00         column 26, line 1, rounded to       21.00       21.00	19.50	Tel emedi ci ne	0						
26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	20.00	Total (sum of lines 1-19) (2)	1, 144, 231						20.00
of column 26, line 20 minus column 26, line 1, rounded to	21.00	Unit Cost Multiplier: column							21.00
column 26, line 1, rounded to									
		of column 26, line 20 minus							
6 decimal places.									
		6 decimal places.							

⁽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.

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CEN	JOHNSON MEMORI		CN: 15-0001	Period:	u of Form CMS-2 Worksheet H-2	
BASIS			HHA CCN:		From 01/01/2019 To 12/31/2019	Part II	pared:
					Home Health	PPS	
	CAPI TAL REL	ATED COSTS			Agency I		
Cost Center Description	NEW BLDG & FI XT (TOTAL FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI O S (# NON PT PHONES)	N DATA PROCESSI NG (WORK ORDERS)	MATERI ALS MANAGEMENT (SUPPLY USAGE)	
	1.00	2.00	4.00	4.01	4. 02	4.03	
1.00Administrative and General2.00Skilled Nursing Care3.00Physical Therapy4.00Occupational Therapy5.00Speech Pathology6.00Medical Social Services7.00Home Health Aide8.00Supplies (see instructions)9.00Drugs10.00DME11.00Home Dialysis Aide Services12.00Respiratory Therapy13.00Private Duty Nursing14.00Clinic15.00Health Promotion Activities16.00Day Care Program17.00Home Delivered Meals Program18.00All Others (specify)19.50Telemedicine20.00Total cost to be allocated22.00Unit cost multiplierCost Center Description	1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	56 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	614, 193 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2 6, 30 274, 21739 ADMI NI STRATI E & GENERAL (ACCUM, COST)	3       42         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	13, 837 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ \end{array}$
1.00Administrative and General2.00Skilled Nursing Care3.00Physical Therapy4.00Occupational Therapy5.00Speech Pathology6.00Medical Social Services7.00Home Health Aide8.00Supplies (see instructions)9.00Drugs10.00DME11.00Home Dialysis Aide Services12.00Respiratory Therapy13.00Private Duty Nursing14.00Clinic15.00Health Promotion Activities16.00Day Care Program17.00Home Delivered Meals Program18.00Holthers (specify)19.50Telemedicine20.00Total (sum of lines 1-19)21.00Total cost to be allocated22.00Unit cost multiplier	4. 04 994, 817 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4. 05 994, 817 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	324, 95 193, 14 135, 59 16 50, 27 17, 91	4         0           3         0           9         0           0         0           1         0           7         0           2         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	8.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 19.\ 00\\ 21.\ 00\\ 21.\ 00\\ 21.\ 00\end{array}$

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS		JOHNSON MEMORIAL		CN: 15-0001	In Lie Period:	u of Form CMS-2 Worksheet H-2	
BASIS	TO TITA COST CEN	ILKS STATISTICAL	HHA CCN:	15-7510	From 01/01/2019 To 12/31/2019	Part II	pared:
					Home Health	PPS	
Cost Center Description	HOUSEKEEPI NG (TOTAL FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS PAI D)	NURSI NG ADMI NI STRATI N (DI RECT NRSI NG HRS)	SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	
	9.00	10.00	11.00	13.00	14.00	15.00	
<ol> <li>Administrative and General</li> <li>OO Skilled Nursing Care</li> <li>OO Physical Therapy</li> <li>OO Occupational Therapy</li> <li>OO Speech Pathology</li> <li>OO Medical Social Services</li> <li>OO Home Health Aide</li> <li>OO Drugs</li> <li>OO DME</li> <li>OO Respiratory Therapy</li> <li>OO Respiratory Therapy</li> <li>OO Private Duty Nursing</li> <li>OO Clinic</li> <li>OO Haalth Promotion Activities</li> <li>OO Day Care Program</li> <li>OO Home Delivered Meals Program</li> <li>OO Home Delivered Service</li> <li>OO Day Care Service</li> <li>OO Day Care Service</li> <li>OO Home Delivered Meals Program</li> <li>OO Home Service</li> <li>OO All Others (specify)</li> <li>SO Total (sum of lines 1-19)</li> </ol>	1, 305 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		17, 232 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$
21.00 Total cost to be allocated 22.00 Unit cost multiplier Cost Center Description	7, 097 5. 438314 MEDI CAL RECORDS & LI BRARY (GROSS CHARGES) 16. 00	0	14, 821 0. 860086		0 0	0.000000	21.00
1.00Administrative and General2.00Skilled Nursing Care3.00Physical Therapy4.00Occupational Therapy5.00Speech Pathology6.00Medical Social Services7.00Home Heal th Aide8.00Supplies (see instructions)9.00Drugs10.00DME11.00Home Dialysis Aide Services12.00Respiratory Therapy13.00Private Duty Nursing14.00Clinic15.00Heal th Promotion Activities16.00Day Care Program17.00Home Delivered Meals Program18.00Homemaker Service19.00All Others (specify)19.50Telemedicine20.00Total (sum of lines 1-19)21.00Total cost to be allocated22.00Unit cost multiplier	1, 158, 497 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 0$

Heal th	Financial Systems		JOHNSON MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	FIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0001	Period:	Worksheet H-3	
				HHA CCN:	15-7510	From 01/01/2019 To 12/31/2019		pared:
				Title	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	Costs (from	Ancillary	Costs (cols		Per Visit	
		col. 28, line		Costs (from	1 + 2)		(col. 3 ÷	
			Part I)	Part II)	'' 2)		col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER							
	COST LIMITATION	OF AGGREGATE	PROGRAW COST, 7	AGGREGATE OF T		MITATION COST, C	JK DENEFICIART	-
	Cost Per Visit Computation		544.054		544.00			1
1.00	Skilled Nursing Care	2.00			514, 95			
2.00	Physical Therapy	3.00						
3.00	Occupational Therapy	4.00	214, 885	0	214, 88	35 973	220.85	3.00
4.00	Speech Pathology	5.00	0	0		0 0	0.00	4.00
5.00	Medical Social Services	6.00	255		25	55 1	255.00	5.00
6.00	Home Health Aide	7.00			79,6		39, 837. 50	•
7.00		7.00						1
7.00	Total (sum of lines 1-6)		1, 115, 846					7.00
					Program Visi	ts		
			1					-
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
					to	Deducti bl es		
					Deductibles	&		
					Coi nsurance			
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation						•	
8.00	Skilled Nursing Care		18020	0		0		8.00
8.01	Skilled Nursing Care		26900	0		-		8.01
				0	1, 50			•
9.00	Physical Therapy		18020	0		0		9.00
9.01	Physical Therapy		26900	0	82			9.01
10.00	Occupational Therapy		18020	0	۹ 5 ⁴	98		10.00
10.01	Occupational Therapy		26900	0	)	0		10.01
11.00	Speech Pathology		18020	0		0		11.00
11.01	Speech Pathology		26900	0		0		11.01
12.00	Medical Social Services		18020			0		12.00
				0				•
12.01	Medical Social Services		26900	0		0		12.01
13.00	Home Health Aide		18020	0		0		13.00
13.01	Home Health Aide		26900	0		0		13.01
14.00	Total (sum of lines 8-13)			0	2,79	93		14.00
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA		Ratio (col. 3	
	· ·	H-2 Part I,	Costs (from	Ancillary	Costs (cols.	(from HHA	÷ col. 4)	
		col. 28, line		Costs (from	1 + 2)	Records)		
			Part I)	Part II)		Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput	-	1.00	2.00	5.00	4.00	5.00	
15 00	Cost of Medical Supplies	8.00	28, 385	0	28, 38	35 0	0. 000000	15 00
	Cost of Drugs	9.00				0 0		
10.00		7.00	Program Visits		Cost of	0 0	0.000000	10.00
					Servi ces			
			Dor	+ D	Jeivices	Dort P		
		D. I.A		t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance			Coi nsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER				HE PROGRAM LI	MITATION COST. C		
	COST LIMITATION							
	Cost Per Visit Computation							1
1 00		0	1 244		1	0 277 709	1	1 1 00
1.00	Skilled Nursing Care	0				0 277, 708		1.00
2.00	Physical Therapy	C				0 169, 837		2.00
3.00	Occupational Therapy	0				0 132, 068		3.00
4.00	Speech Pathology	0				0 0		4.00
5.00	Medical Social Services	0				0 0		5.00
6.00	Home Heal th Ai de					0 0		6.00
7.00	Total (sum of lines 1-6)					0 579, 613		7.00
1.00	Total (Sum OF THES 1-0)	1 0	1 Z, 193	I	I	J J/9, 013	I	1 7.00

APPORTIONMENT OF PATIENT SERVICE COS		rs		Provider C	CN: 15-0001	Period:	Worksheet H-3	
				HHA CCN:	15-7510	From 01/01/2019 To 12/31/2019	Part I Date/Time Pre 8/27/2020 4:0	pare
				Title	xVIII	Home Health	PPS	n piii
	Cost Center Description					Agency I		
		6.00	7.00	8.00	9.00	10.00	11.00	
	mitation Cost Computation				1			
	killed Nursing Care							8.
	killed Nursing Care							8.
	nysical Therapy							9.
	nysical Therapy ccupational Therapy							9.
	ccupational Therapy							10. 10.
	beech Pathology							10.
	beech Pathology							11.
	edical Social Services							12.
	edical Social Services							12.
	ome Health Aide							13.
	ome Health Aide							13.
	otal (sum of lines 8-13)							14.
		Progr	ram Covered Cha	arges	Cost of			
				0	Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject	Subject to	Part A	Not Subject	Subject to	
			to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
		( 00	Coi nsurance	0.00	0.00	Coi nsurance	11.00	
Su	pplies and Drugs Cost Comput	6.00 ations	7.00	8.00	9.00	10.00	11.00	
	ost of Medical Supplies	0	10, 816	0		0 0	0	15.
	ost of Drugs		0			0	0	16.
	Cost Center Description	Total Program						
		Cost (sum of						
		col s. 9-10)						-
DA		12.00	DDOCDAM COST					
	RT I - COMPUTATION OF LESSER	OF AGGREGATE I	PRUGRAM CUSI, A	AGGREGATE OF TH	HE PROGRAM L	IMITATION COST, C	JR BENEFICIARY	
	st Per Visit Computation							1
.00 Sk	killed Nursing Care	277, 708						1.
	nysi cal Therapy	169, 837						2.
00 0	ccupational Therapy	132, 068						3.
. UU   UC	beech Pathology	0						4.
.00 Sp		0						5.
.00 Sp .00 Me	edical Social Services							6.
00 Sp 00 Me 00 Ho	ome Health Aide	0						7.
. 00 Sp . 00 Me . 00 Ho	ome Health Aide otal (sum of lines 1–6)							
00 Sp 00 Me 00 Ho	ome Health Aide	0 579, 613						-
00 Sp 00 Me 00 Ho 00 To	ome Health Aide <u>otal (sum of lines 1–6)</u> Cost Center Description	0						
00 Sp 00 Me 00 Hc 00 Tc	ome Health Aide <u>otal (sum of lines 1-6)</u> Cost Center Description mitation Cost Computation	0 579, 613						
00 Sp 00 Me 00 Hc 00 Tc	ome Health Aide <u>otal (sum of lines 1-6)</u> <u>Cost Center Description</u> <u>mitation Cost Computation</u> <u>killed Nursing Care</u>	0 579, 613						
00 Sp 00 Me 00 Hc 00 Tc 00 Sk 00 Sk 01 Sk	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation cilled Nursing Care cilled Nursing Care	0 579, 613						8
00 Sp 00 Me 00 Hc 00 Tc 00 Sk 01 Sk 00 Ph	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation killed Nursing Care killed Nursing Care hysical Therapy	0 579, 613						8 9
00 Sp 00 Me 00 Hc 00 Tc 00 Sk 01 Sk 00 Ph 01 Ph	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation cilled Nursing Care cilled Nursing Care hysical Therapy hysical Therapy	0 579, 613						8 9 9
00 Sp 00 Me 00 Hc 00 Tc 00 Sk 01 Sk 00 Ph 01 Ph 0.00 Oc	me Health Aide <u>otal (sum of lines 1-6)</u> <u>Cost Center Description</u> <u>mitation Cost Computation</u> <u>killed Nursing Care</u> <u>killed Nursing Care</u> <u>hysical Therapy</u> <u>hysical Therapy</u> <u>ccupational Therapy</u>	0 579, 613						8 9 9 10
00 Sp 00 Me 00 Hc 00 Tc 00 Sk 01 Sk 00 Ph 01 Ph 0.00 Oc 0.01 Oc	me Health Aide <u>otal (sum of lines 1-6)</u> <u>Cost Center Description</u> <u>mitation Cost Computation</u> <u>killed Nursing Care</u> <u>tilled Nursing Care</u>	0 579, 613						8 9 9 10 10
00 Sp 00 Me 00 Tc 00 Tc 00 Sk 00 Ph 01 Sk 00 Ph 01 Ph 0.00 Oc 0.01 Oc 0.01 Sp	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation killed Nursing Care hysical Therapy hysical Therapy ccupational Therapy beech Pathology	0 579, 613						8 9 10 10 11
00 Sp 00 Me 00 Hd 00 Tc 00 Sk 01 Sk 00 Ph 01 Ph 0.00 Oc 0.01 Oc 0.01 Oc 0.01 Sp 0.01 Sp	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation cilled Nursing Care hysical Therapy ccupational Therapy ccupational Therapy beech Pathology beech Pathology	0 579, 613						8 9 10 10 11 11
00 Sp 00 Me 00 Ho 00 To 00 Sk 01 Sk 00 Ph 01 Ph 0.00 Oc 0.01 Oc 0.01 Oc 0.01 Sp 1.01 Sp 2.00 Me	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation cilled Nursing Care hysical Therapy hysical Therapy ccupational Therapy ccupational Therapy beech Pathology beech Pathology edical Social Services	0 579, 613						8 9 10 10 11 11 12
00 Sp 00 Me 00 Ho 00 To 00 Sk 01 Sk 00 Ph 01 Ph 0.00 Oc 0.01 Oc 0.01 Oc 1.00 Sp 1.01 Sp 2.00 Me	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation killed Nursing Care hysical Therapy cupational Therapy cupational Therapy beech Pathology beech Pathology edical Social Services	0 579, 613						8. 9. 10. 10. 11. 11. 12. 12.
00 Sp 00 Me 00 Hc 00 Tc 00 Sk 01 Sk 00 Ph 01 Ph 0.00 Gc 0.01 Oc 1.00 Sp 1.01 Sp 2.00 Me 2.01 Me 3.00 Hc	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation killed Nursing Care hysical Therapy ccupational Therapy ccupational Therapy ccupational Therapy beech Pathology beech Pathology beech Pathology beech Social Services bedical Social Services been Health Aide	0 579, 613						8. 8. 9. 10. 10. 11. 11. 12. 12. 13.
00 Sp 00 Me 00 Hc 00 Tc 00 Sk 01 Sk 00 Ph 01 Ph 0.00 Sp 0.01 Sp 2.00 Me 2.00 Me 3.00 Hc 3.01 Hc	me Health Aide otal (sum of lines 1-6) Cost Center Description mitation Cost Computation killed Nursing Care hysical Therapy cupational Therapy cupational Therapy beech Pathology beech Pathology edical Social Services	0 579, 613						8 9 10 10 11 11 12 12

Health Financial Systems		JOHNSON MEMORI	AL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	TS		Provider C	CN: 15-0001	Period:	Worksheet H-3	
			HHA CCN:	15-7510	From 01/01/2019 To 12/31/2019		pared: 1 pm
			Title	e XVIII	Home Health	PPS	•
					Agency I		
Cost Center Description	From Wkst. C,	Cost to	Total HHA	HHA Shared	Transfer to		
	Part I, col.	Charge Ratio	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 SERVI	CES FURNI SHED E	BY SHARED HOSP	ITAL DEPARTME	INTS		
1.00 Physical Therapy	66.00	0. 337177	0	)	0 col. 2, line 2	. 00	1.00
2.00 Occupational Therapy	67.00	0. 373222	0		Ocol. 2, line 3	. 00	2.00
3.00 Speech Pathology	68.00	0. 592747	0		0 col. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	71.00	0. 327158	0		0col. 2, line 1	5.00	4.00
5.00 Cost of Drugs	73.00	0. 370115	0	)	Ocol. 2, line 1	6.00	5.00

	Financial Systems JOHNSON MEMORIAL			In Lie	eu of Form CMS-2	2552-1
CALCU	LATION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	CN: 15-0001	Peri od:	Worksheet H-4	
		HHA CCN:	15-7510	From 01/01/2019 To 12/31/2019		
		Title	XVIII	Home Health	PPS	F
				Agency I		
			Dont A		rt B	
			Part A	Not Subject to	Subject to Deductibles &	
				Deductibles &		
				Coi nsurance		
			1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUST	FOMARY CHARGE	S			
	Reasonable Cost of Part A & Part B Services				-	
1.00	Reasonable cost of services (see instructions)			0 0		
2.00	Total charges			0 0	0	2.00
3. 00	Customary Charges Amount actually collected from patients liable for payment for	or services		0 0	0	3.00
5.00	on a charge basis (from your records)	51 301 11 003				0.00
4.00	Amount that would have been realized from patients liable for	r payment		0 0	0	4.00
	for services on a charge basis had such payment been made in					
	with 42 CFR §413.13(b)					
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	00 0.000000		
5.00	Total customary charges (see instructions)	<i>.</i>		0 0		
7.00	Excess of total customary charges over total reasonable cost	(complete		0 0	0	7.00
8.00	only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete or	n ly if line		0 0	0	8.00
0.00	1 exceeds line 6)	iry ir irne		0	0	0.00
9.00	Primary payer amounts			0 0	0	9.00
				Part A	Part B	
				Servi ces	Servi ces	
				1.00	2.00	
10 00	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			0		10.00
10.00 11.00	Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers					10.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers				0	
13.00	Total PPS Reimbursement - LUPA Episodes			C	3, 722	
14.00	Total PPS Reimbursement - PEP Episodes			C		14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	S		C	0	15.00
6.00	Total PPS Outlier Reimbursement - PEP Episodes			C	0	16.0
17.00	Total Other Payments				-	
18.00	DME Payments			C	0	17.00
					0	17. 0 18. 0
19.00	Oxygen Payments				000000000000000000000000000000000000000	17.0 18.0 19.0
19.00 20.00	Oxygen Payments Prosthetic and Orthotic Payments	surance)				17.00 18.00 19.00 20.00
19.00 20.00 21.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins	surance)			0 0 0 0 0 0	17.00 18.00 19.00 20.00 21.00
19.00 20.00 21.00 22.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)	surance)			0 0 0 0 0	17.00 18.00 19.00 20.00 21.00 22.00
19.00 20.00 21.00 22.00 23.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins	surance)			0 0 0 0 555, 126	17.00 18.00 19.00 20.00 21.00 22.00 23.00
19.00 20.00 21.00 22.00 23.00 24.00 25.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)	surance)			0 0 0 0 555, 126 0	17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00
19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)	surance)			0 0 0 0 555, 126 0 555, 126 0 555, 126 0	17.00 18.00 19.00 20.00 21.00 23.00 24.00 25.00
19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)			C	0 0 0 0 555, 126 0 555, 126 0 555, 126 0	17.00 18.00 20.00 21.00 23.00 24.00 25.00 26.00 27.00
19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 i	instructions)	)	c	0 0 0 555, 126 0 555, 126 0 555, 126	17.00 18.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00
19.00         20.00         21.00         22.00         23.00         24.00         25.00         26.00         27.00         28.00         29.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 in Total costs - current cost reporting period (line 26 plus line	instructions)	)		0 0 0 555, 126 0 555, 126 0 555, 126 555, 126	17.00 18.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00
19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	instructions) ne 27)	)	c	0 0 0 555, 126 0 555, 126 555, 126 555, 126 0 555, 126 0	17.00 18.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00
19.00         20.00         21.00         22.00         23.00         24.00         25.00         26.00         27.00         28.00         29.00         30.00         30.00         30.50	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	instructions) ne 27)	)		0 0 0 555, 126 0 555, 126 555, 126 555, 126 0 0 0 0 0 0 0	$\begin{array}{c} 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 30. \ 00\\ 30. \ 50\\ \end{array}$
19.00         20.00         21.00         22.00         23.00         24.00         25.00         26.00         27.00         28.00         29.00         30.00         30.00         30.90         30.90	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	instructions) ne 27)	)		0 0 0 555, 126 0 555, 126 0 555, 126 555, 126 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 17. \ 00\\ 18. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 29. \ 00\\ 30. \ 50\\ 30. \ 9\\ \end{array}$
19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 30. 50 30. 99 31. 00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 i Total costs - current cost reporting period (line 26 plus lin OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	instructions) ne 27)	)		0 0 0 555, 126 0 555, 126 555, 126 555, 126 0 0 0 0 0 0 0	$\begin{array}{c} 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 23.\ 00\\ 25.\ 00\\ 25.\ 00\\ 25.\ 00\\ 26.\ 00\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 50\\ 30.\ 99\\ 31.\ 00\\ \end{array}$
19.00         20.00         21.00         22.00         23.00         24.00         25.00         26.00         27.00         28.00         29.00         30.00         30.00         30.00         31.00         31.01	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 i Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions)	instructions) ne 27)	)		0 0 0 555, 126 0 555, 126 0 555, 126 0 555, 126 0 0 0 0 555, 126	$\begin{array}{c} 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 29. \ 00\\ 30. \ 50\\ 30. \ 90\\ 31. \ 00\\ 31. \ 0\end{array}$
19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 30.50 30.50 30.99 31.00 31.01 31.02 32.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions)	instructions) ne 27)	)		0 0 0 555, 126 0 555, 126 0 555, 126 0 555, 126 0 0 0 555, 126 11, 103 0 544, 022	$\begin{array}{c} 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 29. \ 00\\ 30. \ 50\\ 30. \ 50\\ 30. \ 50\\ 30. \ 50\\ 31. \ 00\\ 31. \ 00\\ 32. \ 00\\ 32. \ 00\\ 32. \ 00\\ 32. \ 00\\ 32. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\$
19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.50 30.99 31.00 31.01 31.02 32.00 33.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions) Tentative settlement (for contractor use only)	i nstructi ons) ne 27) ns)	)		0 0 0 555, 126 0 555, 126 0 555, 126 0 555, 126 0 0 0 555, 126 11, 103 0 544, 022 0	$\begin{array}{c} 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 30. \ 00\\ 30. \ 50\\ 30. \ 90\\ 31. \ 00\\ 31. \ 00\\ 31. \ 00\\ 32. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\ 33. \ 00\\$
19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 30.50 30.99 31.00 31.01 31.02 32.00 33.00 34.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration Subtotal (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions) Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32,	instructions) ne 27) ns) and 33)			0 0 0 555, 126 0 555, 126 0 555, 126 0 555, 126 0 0 0 555, 126 11, 103 0 544, 022 0 1	$\begin{array}{c} 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 25. \ 00\\ 25. \ 00\\ 25. \ 00\\ 26. \ 00\\ 27. \ 00\\ 28. \ 00\\ 29. \ 00\\ 30. \ 00\\ 30. \ 50\\ 30. \ 90\\ 31. \ 00\\ 31. \ 00\\ 31. \ 00\\ 31. \ 00\\ 33. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\ 34. \ 00\\$
9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.50 0.99 1.00 1.01 1.01 1.02 2.00 3.00	Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) 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 in Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments (see instructions) Tentative settlement (for contractor use only)	instructions) ne 27) ns) and 33)			0 0 0 555, 126 0 555, 126 0 555, 126 0 555, 126 0 0 0 555, 126 11, 103 0 544, 022 0	$\begin{array}{c} 17.\ 0\\ 18.\ 0\\ 20.\ 0\\ 21.\ 0\\ 22.\ 0\\ 23.\ 0\\ 24.\ 0\\ 25.\ 0\\ 25.\ 0\\ 26.\ 0\\ 27.\ 0\\ 29.\ 0\\ 30.\ 0\\ 30.\ 5\\ 30.\ 9\\ 31.\ 0\\ 31.\ 0\\ 31.\ 0\\ 31.\ 0\\ 31.\ 0\\ 32.\ 0\\ 33.\ 0\\ 34.\ 0\\ 34.\ 0\\ \end{array}$

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED		Provider C	CN: 15-0001		eriod:	Worksheet H-5	
) PR(	IGRAM BENEFI CI ARI ES	HHA CCN:	15-7510	Fi	rom 01/01/2019 o 12/31/2019	Date/Time Prep 8/27/2020 4:01	
					Home Health Agency I	PPS	
		Inpatient Part A Part B		t B			
	_	mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00	0	3.00	4.00	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0		044, 022	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)						3
1	Program to Provider			0		0	3
01 02				0		0	3
03				0		0	3
)4 )5				0		0	
5	Provider to Program			0		0	
50				0		0	3
51				0		0	3
52 53				0		0	
54				0		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0		544, 022	4
0	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after						5
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						5
)1				0		0	5
)2				0		0	5
)3	Provider to Program			0		0	5
50	Provider to Program			0		0	5
51				0		0	5
2	Subtetel (sum of lines E 01 E 40 minus sum of lines			0		0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)			_			6
)1 )2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0		1 0	6
)2 )0	Total Medicare program liability (see instructions)			0		544, 023	c 7
			·	-	Contractor Number	NPR Date (Mo/Day/Yr)	_
		(	)		1.00	2.00	

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0001 Period: From 01/01 To 12/31	/2019 Date/Time Pre					
	Title XVIII Hospita	8/27/2020 4:0	) pm				
		1.00					
PART I - FULLY PROSPECTIVE METHOD							
CAPITAL FEDERAL AMOUNT							
00 Capital DRG other than outlier		445, 200					
01 Model 4 BPCI Capital DRG other than outlier		0					
00 Capital DRG outlier payments	0						
01 Model 4 BPCI Capital DRG outlier payments		0	1				
00 Total inpatient days divided by number of days i		16.18					
00 Number of interns & residents (see instructions)		0.00					
	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and						
1.01) (see instructions)							
00 Percentage of SSI recipient patient days to Medi 30) (see instructions)	care Part A patient days (Worksheet E, part A li	ne 0.00	7.0				
	Percentage of Medicaid patient days to total days (see instructions)						
00 Sum of lines 7 and 8	Sum of Lines 7 and 8						
0.00 Allowable disproportionate share percentage (see	0.00						
.00 Disproportionate share adjustment (see instructi		0	1				
.00 Total prospective capital payments (see instruct	i ons)	445, 200	12.				
		1.00					
PART II - PAYMENT UNDER REASONABLE COST		1.00					
00 Program inpatient routine capital cost (see inst	ructions)	0	1 1.0				
00 Program inpatient ancillary capital cost (see in		0					
00 Total inpatient program capital cost (line 1 plu	0	3.					
00 Capital cost payment factor (see instructions)	0	4.					
00 Total inpatient program capital cost (line 3 x l	ine 4)	0	5.				
		1.00					
PART III - COMPUTATION OF EXCEPTION PAYMENTS							
00 Program inpatient capital costs (see instruction	·	0					
00 Program inpatient capital costs for extraordinar		0	1				
00 Net program inpatient capital costs (line 1 minu		0					
00 Applicable exception percentage (see instruction		0.00					
00 Capital cost for comparison to payments (line 3		0					
00 Percentage adjustment for extraordinary circumst		0.00					
	5	0					
		0					
00 Capital minimum payment level (line 5 plus line		0					
00 Capital minimum payment level (line 5 plus line 00 Current year capital payments (from Part I, line	12, as applicable)	-					
Capital minimum payment level (line 5 plus line Current year capital payments (from Part I, line Current year comparison of capital minimum payme Corryover of accumulated capital minimum payment	12, as applicable) Int level to capital payments (line 8 less line 9	-	1				
<ul> <li>Capital minimum payment level (line 5 plus line</li> <li>Current year capital payments (from Part I, line</li> <li>Current year comparison of capital minimum payment</li> <li>Carryover of accumulated capital minimum payment</li> <li>Worksheet L, Part III, line 14)</li> </ul>	e 12, as applicable) ent level to capital payments (line 8 less line 9 e level over capital payment (from prior year	7) 0 0	11.				
<ul> <li>Capital minimum payment level (line 5 plus line Current year capital payments (from Part I, line Current year comparison of capital minimum payme Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level</li> </ul>	e 12, as applicable) ent level to capital payments (line 8 less line 4 e level over capital payment (from prior year to capital payments (line 10 plus line 11)	P) 0 0 0 0	11. 12.				
<ul> <li>Capital minimum payment level (line 5 plus line Current year capital payments (from Part I, line Current year comparison of capital minimum payme Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level Current year exception payment (if line 12 is po</li> </ul>	2 12, as applicable) ent level to capital payments (line 8 less line 6 c level over capital payment (from prior year to capital payments (line 10 plus line 11) esitive, enter the amount on this line)		11. 12. 13.				
<ul> <li>Capital minimum payment level (line 5 plus line Current year capital payments (from Part I, line Current year comparison of capital minimum payme Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)</li> <li>Not comparison of capital minimum payment level Current year exception payment (if line 12 is po Carryover of accumulated capital minimum payment</li> </ul>	12, as applicable) 12, as applicable) 14, and level to capital payments (line 8 less line 6 14, level over capital payment (from prior year 15, to capital payments (line 10 plus line 11) 16, sitive, enter the amount on this line) 16, level over capital payment for the following payment following payment following payment for the following payment for the following payment for the following payment following p		11. 12. 13.				
<ul> <li>Capital minimum payment level (line 5 plus line Current year capital payments (from Part I, line Current year comparison of capital minimum payme Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum payment level Current year exception payment (if line 12 is po Carryover of accumulated capital minimum payment (if line 12 is negative, enter the amount on thi</li> </ul>	12, as applicable) ent level to capital payments (line 8 less line 6 level over capital payment (from prior year to capital payments (line 10 plus line 11) sitive, enter the amount on this line) level over capital payment for the following pe s line)	9) 0 0 0 0 0 0 0 0 0 0	11. 12. 13. 14.				
<ul> <li>Capital minimum payment level (line 5 plus line Current year capital payments (from Part I, line Current year comparison of capital minimum payme Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)</li> <li>Not comparison of capital minimum payment level Current year exception payment (if line 12 is po Carryover of accumulated capital minimum payment</li> </ul>	2 12, as applicable) ent level to capital payments (line 8 less line 6 c level over capital payment (from prior year to capital payments (line 10 plus line 11) psitive, enter the amount on this line) c level over capital payment for the following pa s line) ment (see instructions)		11. 12. 13. 14. 15.				